COVID-19 Health Care Verification Form

Employee Name: ______________________________

The above-mentioned individual is a Texas State University Employee who has requested workplace modifications at Texas State University on the basis of an underlying medical condition that could be affected by COVID-19. In order to determine whether the employee qualifies for services, we ask that you as their health care provider please provide the following information. Once completed, please return the completed form to your patient and/or the Texas State University Americans with Disabilities Act (ADA) Compliance Coordinator (contact information below).

1. Please identify which of the following conditions the individual has been diagnosed with:
   - ☐ Chronic lung disease such as emphysema, chronic bronchitis, or idiopathic pulmonary fibrosis
   - ☐ Moderate to severe asthma
   - ☐ Serious heart conditions such as heart failure, coronary artery disease, cardiomyopathy, or congenital heart disease
   - ☐ Immunocompromised conditions such as cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications. Immunocompromised states from solid organ transplants.
   - ☐ Severe obesity (body mass index [BMI] of 40 or higher)
   - ☐ Diabetes, type 1 or 2 or gestational
   - ☐ Chronic kidney disease requiring dialysis
   - ☐ Liver disease such as cirrhosis or chronic hepatitis
   - ☐ Hemoglobin disorders such as sickle cell disease and thalassemia
   - ☐ Neurologic Conditions
   - ☐ Cerebrovascular Disease

2. Date of last medical evaluation:
3. Please describe the Employee’s current functional limitations and the risks COVID-19 would have on the employee in the workplace environment.

4. If available, please attach copies of any relevant medical records to this form.

Certifying Professional – By signing below (print/type), you are confirming that you are the qualified healthcare professional who is providing the information above.

Name:

License #:

Address:

Phone:

Signature: ____________________________ Date: ____________________

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Please return this form to your patient/the employee and/or submit to ADACoordinator@txstate.edu.
If you have any questions regarding your patient’s request, feel free to contact my office
512 408-1201