FAYETTEVILLE STATE UNIVERSITY

Employee Flexibility Request Form for On-Site Work

I. EMPLOYEE DATA			
Employee Name:		**Date:**	Click or tap to enter a date.
Position:			
Contact Information: *(email/phone)*			
Department:		**Supervisor Name:**	

II. NATURE OF REQUEST

Please select what you are requesting from the options below. You will note your reason(s) in the next section.

Work Type	*Proposed Start Schedule*	*Workdays*	*Proposed Start Date*	*Proposed End Date*
On-Site Work	☐ ***Full-Time*** ☐ ***Part-Time:*** ***Hrs.***	**M T W T F**	Click or tap to enter a date.	Click or tap to enter a date.
Telework	☐ ***Full-Time*** ☐ ***Part-Time:*** ***Hrs.***	**M T W T F**	Click or tap to enter a date.	Click or tap to enter a date.
Leave	☐ ***Full-Time*** ☐ ***Part-Time:*** ***Hrs.***	**M T W T F**	Click or tap to enter a date.	Click or tap to enter a date.

Provide any additional scheduling details related to your request:

☐ ***Check box here if you are unable to telework in any way due to your job responsibilities or technology considerations.***

III. REASON(S) FOR REQUEST

Select all options that apply to your request above. (Documentation requirements, if any, are listed on the next page.)

☐ Based on my age (65 or older) and/or one or more medical conditions, I would face a high risk of severe illness if I were to become infected with COVID-19.

☐ I have childcare needs due to a school/childcare facility closing or unavailable childcare provider related to COVID-19.

☐ I have eldercare needs due to an eldercare facility closing related to COVID-19.

☐ I am subject to a federal, state, or local quarantine or isolation order or have been advised by a healthcare provider to self- quarantine related to COVID-19.

☐ I am caring for an individual who is subject to a federal, state, or local quarantine or isolation order or has been advised by a healthcare provider to self-quarantine related to COVID-19.

☐ I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.

☐ Other medical reason.

☐ Other non-medical reason *(explain):* _____

IV. SIGNATURE

Employee Signature:		**Date:**	

Please submit this completed request form to Kay Faircloth in HR for review. Your request will be discussed with your supervisor. You will receive a written response to your request.

V. HR USE ONLY

☐ **Approved** ☐ **Denied**	**HR Representative:**		**Date:**	

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V. Documentation Requirements Based on Request Reason

Supporting documentation will be required for as indicated below, based on the reason for your request for consideration for flexibility.

Based on my age (65 or older) and/or one or more medical conditions, I would face a high risk of severe illness if I were to become infected with COVID-19.

- If request is due to medical condition that presents high risk of severe illness, provide a doctor's note on the doctor's letterhead indicating that you are at high risk for severe illness based on current CDC guidance, which can be found at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html. Your doctor should include the start and end dates that they recommend you to be approved for telework or leave.

I have childcare needs due to a school/childcare facility closing or unavailable childcare provider related to COVID-19.

- Complete and submit with this form the EPSL-EFMLA Form, which can be found at https://www.uncfsu.edu/faculty-and-staff/departments-and-offices/office-of-human-resources/covid-19-employee-resources

I have eldercare needs due to an eldercare facility closing related to COVID-19.

- Attach to this form the following details:
  - Name and relationship of person for whom you are providing care
  - Name of the eldercare facility that is closed, contact person for the facility and phone number

I am subject to a federal, state, or local quarantine or isolation order or have been advised by a healthcare provider to self-quarantine related to COVID-19.

- Provide evidence of order or doctor's note on letterhead indicating advice to self-quarantine

I am caring for an individual who is subject to a federal, state, or local quarantine or isolation order or has been advised by a healthcare provider to self-quarantine related to COVID-19.

- Provide evidence of order or doctor's note on letterhead indicating advice to individual to self-quarantine
- Provide name and relationship of person for whom you are caring

I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.

- Note from healthcare provider on letterhead with advice to self-quarantine or document indicating date of COVID-19 testing

Other medical reason.

- Note from healthcare provider on letterhead explaining reason for requested absence. Please note, you may wish to speak with Kay Faircloth in the Office of Human Resources prior to contacting your healthcare provider, as more extensive documentation may be required.