STAFF REQUEST FOR ALTERNATIVE FLEXIBLE WORK ARRANGEMENT

The University of Texas at Austin

FOR COMPLETION BY EMPLOYEE

Please complete this form along with other approved medical documentation as described below. The University of Texas at Austin maintains records and documents created for this arrangement as confidential and in separate files from the department personnel files. An Alternative Flexible Work Arrangement (FWA) is a temporary arrangement for employees with dependents with certain medical conditions. This arrangement is not the same as Family Medical Leave (FML) or an accommodation under the American with Disabilities Act (ADA). Failure to provide complete and sufficient employee and health care certifications or other medical records may result in denial of your request.

An Alternative FWA is only available to staff with individuals **residing in their household** who have been advised to limit their exposure to others due to the increased risk of infection with COVID-19, and who have one of the following medical conditions:

- Solid organ transplants or stem cell transplants;
- Currently in cycle for chemotherapy or cancers associated with immune deficiency (leukemias and lymphomas);
- Chronic inflammatory diseases treated with systemic corticosteroid therapy > 20mg prednisone daily, immunomodulator medications, and/or biologic agents;
- Primary immune deficiency disorders;
- Immune deficiencies due to HIV infection;
- Sickle cell disease; or
- Surgical asplenia

Since some jobs cannot be done remotely, not all requests will be approved. Employees who are not approved for an Alternative FWA, may use their own available paid leave accruals in accordance with university policy. Employees who exhaust their available paid leave may apply for an unpaid leave of absence through their departments.

EMPLOYEE INFORMATION

Name _____

EID _____

Department _____

College or School _____

ACKNOWLEDGEMENTS

I am requesting an Alternative Flexible Work Arrangement for the Fall 2021 semester.
I affirm and acknowledge that (please check each box):

- ◯ A resident of my household has been advised to limit their contact with others due to the increased risk of infection with COVID-19, and has one of the medical conditions listed above.
- ◯ The decision made in response to this request is final.
- ◯ If my request is denied, I may still be eligible for other paid or unpaid leaves and should contact Human Resources to discuss those options.
- ◯ I must submit documentation supporting my request as indicated below.

SUPPORTING DOCUMENTATION

Please submit the Immunocompromised Resident Household Member Certification – Staff form within 15 calendar days. As a replacement for this form, you may instead submit the following alternative documentation:

- Previously submitted FMLA Certification of Healthcare Provider form which documents resident household member's eligible condition; or
- Previously submitted Sick Leave Pool Certification of Healthcare Provider form which documents resident household member's eligible condition; or
- Documentation from the dependent's medical record that identifies the eligible medical condition and is endorsed by a licensed healthcare provider; or
- A letter signed by the resident household member's physician which documents their eligible condition.

SIGNATURE AND CERTIFICATION

By signing below, I certify that I have read, understand, and agree with the above statements, and that all the information provided on this form is true and correct to the best of my knowledge. I also understand that making false representations on this form may result in employment action up to and including termination.

Employee's Signature **Date**

Completed forms should be submitted to Human Resources – Benefits and Leave Management.