Carnegie Mellon University
Disability Resources

COVID-19 Medical Information Request Form
(Students with CDC High-Risk Medical Conditions)

This COVID-19 Medical Information Request Form is to be used by students who serve as teaching assistants, research assistants, or have other paid on-campus experiences. It is to be used by students who are requesting an accommodation related to these on-campus paid experiences because of a medical condition that places them at a high-risk of severe illness from COVID-19, as determined by the CDC.

- Section I should be completed by the student.
- Section II should be completed by the student's physician or health care provider.
- Completed forms should be returned to the Office of Disability Resources via email: access@andrew.cmu.edu.

SECTION I – To be completed by the student

Name

Andrew ID

Email

Preferred Phone Number

Type of paid experience(s):

- [ ] Teaching Assistant
- [ ] Research Assistant
- [ ] Instructor of Record
- [ ] Residential Assistant
- [ ] Community Advisor
- [ ] Tutor
- [ ] Academic Coach
- [ ] Front Desk Assistant
- [ ] Other

Is successful completion of the above experience(s) an educational requirement that you must fulfill in order to receive your degree?

- ◯ Yes
- ◯ No
- ◯ I checked more than one type of experience. One of the above experiences is an educational requirement and one is not.

Type of accommodation(s) requested

- ◯ Ability to perform on-campus responsibilities remotely
- ◉ Other

If other, please specify:

_____
_____
_____
_____

Supervisor Name
Supervisor Title
Supervisor Email Address

Additional Supervisor Name
Additional Supervisor Title
Additional Supervisor Email

Name of academic or administrative department

Additional Comments

_____
_____
_____
_____

Release of Information

I hereby authorize the release of the following information to Carnegie Mellon University's Office of Disability Resources for the purpose of determining the availability of reasonable accommodations due to COVID-19. I further authorize Carnegie Mellon University to seek clarification of this documentation, if necessary, by contacting my physician or medical provider.

Signature Date

SECTION II – To be completed by physician or health care provider.

The above-named student has requested an accommodation for a medical condition that the CDC has determined places people at a high-risk for severe illness from COVID-19. As the student's physician or medical provider, you are asked to complete this form.

1. Please identify which, if any, of the following medical condition(s) the above-named student has been diagnosed with:

   ☐ Immunocompromised state (weakened immune system) from solid organ transplant, blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines

   ☐ Obesity (body mass index [BMI] of 30 or higher) (note BMI of 30, not 40 which is what is on our form)

- [ ] Sickle Cell Disease
- [ ] Diabetes (Type 1 and Type 2 diabetes mellitus)
- [ ] Cerebrovascular Disease (affects blood vessels and blood supply to the brain)
- [ ] Cystic Fibrosis
- [ ] Hypertension or high blood pressure
- [ ] Neurologic conditions (such as dementia)
- [ ] Liver disease
- [ ] Pregnancy
- [ ] Thalassemia (a type of blood disorder)
- [ ] Smoking (current or former)
- [ ] Cancer
- [ ] Chronic Kidney Disease
- [ ] COPD (Chronic Obstructive Pulmonary Disease)
- [ ] Serious Heart Conditions (such as heart failure, coronary artery disease or cardiomyopathies)
- [ ] Asthma (moderate-to-severe)
- [ ] Pulmonary Fibrosis (having damaged or scarred lung tissue)

2. What accommodations or modifications would enable the student to perform the functions of their on-campus paid experience during the COVID-19 pandemic?

   _____
   _____
   _____
   _____

Thank you for your assistance in providing this information. Please sign below.

Signature	Date
Provider Name (printed)	Telephone #
Name of Practice	Email address