HENDERSON COUNTY PUBLIC SCHOOLS

Medical Provider Certification

"High-Risk" Household Member

--TO BE COMPLETED BY A PHYSICIAN OR QUALIFIED HEALTH CARE PROFESSIONAL--

The purpose of this form is to assist Henderson County Public Schools in determining whether, or to what extent, a reasonable accommodation is necessary for an employee with a household member who is considered to be "high-risk".

Employee Information:

Name: _____

School/District Site: _____ Position/Title: _____

Family Member Considered to be "High-Risk"

Name: _____

Son _____ Daughter _____ Spouse _____ Other _____

Please return this form to sickleave@hcpsnc.org

Name of Physician (please print or type):_____

Office Address: _____

City, State and Zip Code: _____

Patient Name: _____

Patient Address:_____

By signing below, I confirm that I am treating this patient who is at an increased risk of severe illness from COVID-19 due to one of the following health conditions identified by the Centers for Disease Control.
(There is no need to identify the specific condition.)

- Chronic kidney disease
- COPD (Chronic obstructive pulmonary disease)
- Immunocompromised state (weakened immune system)
- Obesity (body mass index [BMI] of 30 or higher)
- Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Sickle cell disease
- Type 2 diabetes mellitus

Physician Signature: _____ Date: _____