



Jackson County Central Schools
1128 North Highway
Jackson, MN 56143
507-847-3608

Jackson County Central Schools
Medical Certification of Serious Health Condition Form
COVID-19 Accommodation Request

This form needs to be completed by the employee and the employee's health care provider and returned to the Jackson County Central School District Office at the address listed above.

Covid-19 Related Health and Safety Precautions in place for employees:

- Self Health Screenings for students and staff
- Reduction of the number of students on site while in the Hybrid Instruction Model
- Face coverings for all staff and students in grades K-12
- Implementation of Minnesota Department of Health protocols for illness or exposure
- Limitations of non-essential visitors
- Signage and floor markings to indicate flow of traffic and social distancing guidelines
- Bottle filling only at drinking fountains
- Increased availability of hand sanitizer throughout buildings
- Minimizing use of shared spaces (media center, cafeteria, hallways, etc.)
- Increased cleaning and disinfecting protocols
- Limiting shared supplies and objects
- Other health and safety precautions as directed by the Minnesota Department of Health, Centers for Disease Control and Minnesota Department of Education.

1. EMPLOYEE SECTION

Name:

Position:

Accommodation Requested:

- _____ Temporary unpaid and/or paid leave.
 This may include the use of Families First Coronavirus Response Act leave, Family Medical Leave for qualifying employees or use of available sick leave.
 Leave Start Date _____ Expected Return Date _____
- _____ Telework for positions where job duties are not impacted.
- _____ Change in assignment and/or location to practice social distancing where job duties are not impacted.
- _____ Other -Please explain

Employee Signature

Date

2. HEALTH CARE PROVIDER

I certify that the above-named individual is not able to perform the functions of his/her position without reasonable accommodation based on the job description attached to this form due to the following:

Accommodation Requested:

_____ Temporary unpaid and/or paid leave.
This may include the use of Families First Coronavirus Response Act leave, Family Medical Leave for qualifying employees or use of available sick leave.

Leave Start Date _____ Expected Return Date _____

_____ Telework for positions where job duties are not impacted.

_____ Change in assignment and/or location to practice social distancing where job duties are not impacted.

_____ Other-Please explain

Health Care Provider Signature

Date

Practice/Specialization

Address:

Phone:

Fax:

3. EMPLOYER SECTION

Employer Remarks:

Building Principal/Supervisor Signature/Date: _____