



# Human Resources

## Medical Certification for Temporary Modified Work Arrangement Due to High-Risk Coronavirus Category

**I consent to my physician providing the medical certification requested below to the Office of Human Resources at the University of Richmond.**

Employee name \_\_\_\_\_

Name of household member (if applicable) \_\_\_\_\_

Employee or household member signature \_\_\_\_\_

Date \_\_\_\_\_

### Medical Certification

I certify that the above-named individual or a member of their immediate household has a medical condition that puts them or the person(s) they live with at increased risk of serious illness if they become infected with COVID-19.

Physician name \_\_\_\_\_

Physician signature \_\_\_\_\_

Date \_\_\_\_\_

Please fax this form to University of Richmond Human Resources at 804.287.1282 or email to [urhr@richmond.edu](mailto:urhr@richmond.edu)

Thank you.

-----  
FOR HUMAN RESOURCES USE ONLY

Modified Work Arrangement approved (specify) and date effective \_\_\_\_\_

Modified Work Arrangement declined and date of decision \_\_\_\_\_

**Human Resources**  
Weinstein Hall  
231 Richmond Way  
University of Richmond, VA 23173  
(804) 289-8747  
Fax: (804) 287-1282  
[urhr@richmond.edu](mailto:urhr@richmond.edu)  
[hr.richmond.edu](http://hr.richmond.edu)