Face Covering Accommodation Form

This form must be completed in its entirety by individuals who believe they require an accommodation to the Knox College Face Covering Protocol. The Protocol requires all faculty, staff, students and visitors to wear face coverings in College buildings, vehicles, and on College grounds when social distancing cannot be maintained.

Face coverings are required to prevent the spread of COVID-19. Face coverings must be worn by everyone except children younger than 2 years old, people with physical or intellectual disabilities who are unable to remove a face covering without assistance, and on rare occasions, individuals with severe breathing problems.

Name of Person Requesting Accommodation: ___________________________________

Name of Parent/Guardian (only if the person seeking accommodation is under 18 years of age): ____________________________

Contact information

Phone Number: _______________(home) _______________(mobile)

Email address: _______________________________________________

Emergency Contact (name): _________________________(relationship)________________

Emergency Contact phone number:  ______________________________________________

Reasons for request for accommodation to Face Covering Protocol (please describe the basis for your request as completely as possible).

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Verification of Request
(To be completed by the physician/health care provider of the person requesting accommodation)

Name of physician / health care provider completing this form:___________________________

Please describe the medical basis for the individual’s inability to wear a face covering (please explain, with specificity, the nature of the individual’s medical condition and why it is medically contraindicated for the individual to comply with the protocol attached).

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Please indicate the specific detrimental effect of the face covering requirement on functioning in each area below:

Circle Yes or No; where answer is Yes, explanation is required.

1. Circulatory System. Detrimental effect: YES NO
   Explanation: _______________________________________________________________

2. Respiratory System. Detrimental effect: YES NO
   Explanation: _______________________________________________________________

3. Exocrine System (skin). Detrimental effect: YES NO
   Explanation: _______________________________________________________________

4. Immune/Lymphatic System. Detrimental effect: YES NO
   Explanation: _______________________________________________________________

5. Nervous System. Detrimental effect: YES NO
   Explanation: _______________________________________________________________

If there are other medical reasons that require this accommodation, please explain below:

____________________________________________________________________________
____________________________________________________________________________

Would the condition that limits the person’s ability to comply with the face covering protocol be assisted by any of the accommodations listed below?
• Modifications to the face covering itself?  YES    NO

If yes, describe modifications needed (changes to material, fastening system, style)
________________________________________________________________________

• Regular breaks from the requirement to wear a face covering?  YES    NO

If yes, describe frequency and length of breaks needed:
_________________________________________________________________________

Are there any other accommodations that would address the individual’s needs and enable compliance with the face covering protocol?
_________________________________________________________________________

*If the physician states that face coverings may not be required under any circumstances:*

Is the individual able to be around others who wear face coverings or protective equipment?  

YES    NO

If no, explain: ____________________________________________________________

Is the individual able to be around others who are also unable to wear face coverings if social distancing is maintained?

YES    NO

If no, explain; ____________________________________________________________

The College reserves the right to seek fitness for duty information for employees and an independent medical assessment for students to verify the information provided on this form.

Signature of Person Requesting Accommodation: ________________________________ Date

Parent/Guardian Signature (minors only): ________________________________ Date

Physician Signature: ________________________________ Date

Physician Phone Number: ________________________________

Please return the completed form via email, fax or postal mail to:
Knox College Office of Human Resources
2 East South St., Box K-200, Galesburg, IL  61401
Email: hr@knox.edu  Fax: 309-341-7090