

**Request for Exemption from Emergency/Disaster Staff Schedule – Medical Supplement**

Form Revision Date 8/26/2015

**Section I: For Completion by OTS Employee**

OTS Section/Unit: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Last First Middle Initial

Employee ID: \_\_\_\_\_ Employee Job Title: \_\_\_\_\_

**Section II: For Completion by Health Care Provider**

Your patient is an employee of the State of Louisiana Division of Administration Office of Technology Services (OTS), and may be called upon to perform emergency support functions including but not limited to 24 hour scheduling, physical duties/demands and potential exposure to poor environmental conditions. Breaks and meal periods are permitted. **Note: This scheduling is outside of the scope of and does not apply to, his/her normal scheduling.** Please indicate if your patient is able to perform duties as follows:

Description of duty	Is the employee able to perform this duty?
Moderate physical duties/demands (such as: removing/delivering smaller computer hardware items (monitors, keyboards), emptying trash)	<input type="checkbox"/> Yes <input type="checkbox"/> No, through _____ (date) <input type="checkbox"/> Patient's condition is likely to be permanent.
Heavy physical duties/demands (such as: removing/delivering larger computer hardware items (servers, desktops, laptops, laying cable, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No, through _____ (date) <input type="checkbox"/> Patient's condition is likely to be permanent.
Can employee work a 12-hour shift?	<input type="checkbox"/> Yes <input type="checkbox"/> No, through _____ (date) <input type="checkbox"/> Patient's condition is likely to be permanent.
Can the employee be exposed to poor environmental conditions such as heat, poor lighting, working outdoors, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No, through _____ (date) <input type="checkbox"/> Patient's condition is likely to be permanent.
Can the employee be exposed to large crowds and/or stressful situations resulting from an emergency of disaster without significant health risk to himself/herself?	<input type="checkbox"/> Yes <input type="checkbox"/> No, through _____ (date) <input type="checkbox"/> Patient's condition is likely to be permanent.

Additional Comments:

Physician Signature: \_\_\_\_\_ Phone Number: ( ) - \_\_\_\_\_

Printed Name: \_\_\_\_\_ Practice Type: \_\_\_\_\_

**Section III: Employee Certification**

**By my signature I certify the information provided on this form to be true and correct.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Printed Name: \_\_\_\_\_

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## Section IV: For Office Use Only

### Emergency/Disaster Exemption Review Dates

Request Received Date:	Review by Date:	Decision Date: <input type="checkbox"/> Approved <input type="checkbox"/> Declined
Approved To Date:	Notification Date:	Appeal by Date:

**OTS Committee Comments:**

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**Signature of OTS Committee Head/Date:**

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Appeal Received Date:	Decision Date: <input type="checkbox"/> Approved <input type="checkbox"/> Declined	Notification Date:
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**CIO or his/her designee Comments:**

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**Signature of OTS CIO or his/her designee/Date:**

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