WELLS FARGO

Nonroutine event code request

For U.S. employees: Use this form to request a medical accommodation to use the nonroutine event code under direction by a health professional to quarantine, due to COVID-19.

If you need a leave of absence due to your own illness or to care for a family member do not use this form. Contact the Wells Fargo Leave and Claim Administrator Lincoln Financial at 1-866-213-2937.

Consult the Company's Our Workplace page available at **teamworks.wellsfargo.com** for more information regarding COVID-19 efforts to ensure safety and provide medical accommodations. Providing false information or documentation shall constitute a violation of Company policy.

For questions regarding this requirement or returning to work, employees can speak with an Employee Care COVID-19 Support Specialist by calling 1-877-HRWELLS (1-877-479-3557), option 8.

EMPLOYEE INSTRUCTIONS

- Complete page one and then send to your health professional. To avoid processing delays and to protect your privacy, **DO NOT SEND TO YOUR MANAGER**.
- Instruct your health professional to complete page two and return directly to Human Resources through the designated email and/or secured fax referenced below. The document must be legible and cannot be sent using secure functionality or password protection.

This form must be returned within five calendar days from first use of nonroutine event Time Tracker code to:
Fax: 866-922-3177 or Email: COVID19DOCUMENTATION@wellsfargo.com. You are required to remain available to meet with and provide information to Wells Fargo, including your manager, during your regularly scheduled work hours.

*Indicates required information

*PATIENT NAME:

*PATIENT RELATIONSHIP TO EMPLOYEE

*EMPLOYEE NAME:

*EMPLOYEE ID:

*PERSONAL EMAIL ADDRESS:

*PERSONAL PHONE/CELL NUMBER:

*EMPLOYEE'S SIGNATURE:

*DATE:

© 2022 Wells Fargo Bank, N.A. All rights reserved.

HEALTH PROFESSIONAL INSTRUCTIONS:

The employee identified above has requested time to self-quarantine from their existing job duties due to COVID-19.
Please do not provide any information about the employee's medical condition or that of their family member.

HEALTHCARE PROFESSIONAL: COMPLETE THIS SECTION IF PATIENT IS IN THE EMPLOYEE'S HOUSEHOLD

☐ Patient instructed to quarantine due to own positive test for COVID-19.

Quarantine dates: From: ____________ To: ____________

☐ Patient presumed positive for COVID-19 and instructed to quarantine.

Quarantine dates: From: ____________ To: ____________

HEALTHCARE PROFESSIONAL: COMPLETE THIS SECTION IF PATIENT IS THE EMPLOYEE

☐ Employee instructed to quarantine due to own pending or positive test for COVID-19.

Quarantine dates: From: ____________ To: ____________

☐ Employee presumed positive for COVID-19 and instructed to quarantine.

Quarantine dates: From: ____________ To: ____________

Signature of Health Care Provider (sign and print name):		Date:
Type of Practice:	Practice Name & Address:	Phone Number (with area code):

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.