WELLS FARGO

Nonroutine event code request cover sheet

Request for medical accommodation based upon self-identified high-risk pre-existing medical condition, as defined by the Centers For Disease Control and Prevention ("CDC"), or direction by a health professional to quarantine due to COVID-19

Employees requesting continued ability to self-quarantine should complete this form, provide supporting documentation from a public health official, their health professional, or, if appropriate, the health professional of a family member within the household, supporting the need for the accommodation and return within five calendar days to:

- Fax: **866-922-3177** or
- Email: **COVID19DOCUMENTATION@wellsfargo.com**

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

- To avoid processing delays and to protect your privacy, employees must complete cover page (page 1), attach supporting documents (page 2 or alternate documents), and return to Human Resources only, through the designated email and/or secured fax referenced above. The document must be legible and cannot be sent using secure functionality.
- DO NOT SEND TO YOUR MANAGER.
- During the period of the Quarantine Accommodation Evaluation and subsequent approval, 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

*NAME: _____

*EMPLOYEE ID: _____

*PERSONAL EMAIL ADDRESS: _____

*PERSONAL PHONE/CELL NUMBER: _____

*EMPLOYEE'S SIGNATURE: _____

*DATE: _____

For help with supporting employees through this requirement or returning to working, employees can speak with a Team Member Care COVID-19 Support Specialist by calling 1-877-HRWELLS (1-877-479-3557), option 8.

TO HEALTH PROFESSIONAL:

The employee identified above has requested time to self-quarantine from their existing on-site job duties on the basis that the employee or a family member within their household is at risk due to COVID-19. We need additional information in order to evaluate that request.

Please do not provide any information about the employee's medical condition (or that of their family member) beyond what is necessary to respond to the questions below.

If you determine that the employee has a medical condition that makes them unable to perform one or more of the essential functions of their position in light of the COVID-19 pandemic, including the ability to work on-site or otherwise without posing a direct threat to the employee, please complete the corresponding questions to determine what accommodation, if any, is needed. Please do not provide information relating to any other medical conditions.

Any medical and/or disability-related information shared about this patient for accommodation evaluation will be kept confidential.

*Please select one of the options below

☐ Health professional is not required to complete this form. He/She may submit medical correspondence validating the high-risk medical condition via fax, email, facilities medical form, and/or documentation.

☐ Health professional may alternatively complete attestation below.

[_____] is a patient under my medical care. My patient has a pre-existing medical condition that places them at greater risk of severe illness if they contract COVID-19, including certain pre-existing medical conditions as described by the CDC, or those "Others At Risk" which include pregnant women.

Patient's Name

Please provide any additional information that might be useful in processing this accommodation request, including any potential alternatives to the quarantine accommodations suggested above: _____

_____

_____

_____

_____

Signature of Health Care Provider (sign and print name): Printed 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.