Accommodation Medical Request Form

The ADA Division of the Office for Access and Equity (OAE) is requesting your assistance in facilitating a reasonable accommodation for a University of Illinois employee who has requested a workplace accommodation per the Americans with Disabilities Act Amendment Act (ADAAA). The employee listed below has informed the ADA Division OAE of their diagnosis. This form is used to verify that they qualify as a person with a disability and helps the ADA Division determine how to best accommodate the employee, when possible. When an employee requests a workplace accommodation due to a qualifying disability, this form must be completed and signed by the current treating health care provider. **Please fax documentation to the ADA Division of the Office for Access and Equity at 217-244-9136.** If you have any questions, please contact OAE at 217-333-0885 or adadivision@illinois.edu.

Please note that under the ADAAA, a disability means with respect to an individual: (a) a physical or mental impairment that substantially limits one or more life activities of such individual; (b) a record of such an impairment; or (c) being regarded by the employer as having such an impairment. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. If you are unsure if the employee qualifies as having a disability, please complete this form and the ADA Coordinator will make a determination as to whether the employee's limitations meet the ADAAA definition of a disability.

Section 1: Completed By Employee

Employee Name: _____ DOB: _____ Employee UIN: _____

Job Title:_____ Department: _____

Summary of Job Duties or copy of Job Description: _____

Section 2: Completed by the Health Care Provider

Employee's Diagnosis

Please identify what the diagnosis(es) is for the above-named employee/patient:

_____

Does the impairment substantially limit a major life activity as compared to most people in the general population?

☐ Yes ☐ No

If yes, what major life activity(s) is affected?

- ☐ Bending
- ☐ Breathing
- ☐ Caring for Self
- ☐ Concentrating
- ☐ Hearing
- ☐ Interacting with others
- ☐ Learning
- ☐ Lifting
- ☐ Performing manual tasks
- ☐ Reaching
- ☐ Reading
- ☐ Seeing
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Thinking
- ☐ Walking
- ☐ Working
- ☐ Eating
- ☐ Standing
- ☐ Other (describe): _____

What major bodily function(s) is affected?

- ☐ Bladder
- ☐ Bowel
- ☐ Brain
- ☐ Cardiovascular
- ☐ Immune
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinary
- ☐ Hemic
- ☐ Organ Transplant
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Normal Cell Growth
- ☐ Other (describe): _____
- ☐ Reproductive
- ☐ Respiratory
- ☐ Special Sense Organs and Skin
- ☐ Circulatory

Please add any additional information regarding the employee's diagnosis(es): _____

Workplace Accommodation Determination

How does the employee's limitation(s) interfere with their ability to perform the job function(s) or access a benefit of employment? _____

Employee is unable to or has difficulty with:

- ☐ Bending
- ☐ Breathing
- ☐ Learning
- ☐ Speaking
- ☐ Reaching
- ☐ Interacting with Others
- ☐ Seeing
- ☐ Sitting
- ☐ Eating
- ☐ Sleeping
- ☐ Reading
- ☐ Walking
- ☐ Working
- ☐ Hearing
- ☐ Standing
- ☐ Thinking
- ☐ Caring for Self
- ☐ Concentrating
- ☐ Performing Manual Tasks
- ☐ Lifting
- ☐ Other (describe): _____

Major bodily function(s) affected:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs and Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Circulatory
☐ Immune	☐ Organ Transplant	☐ Other (describe): _____	

Please add any additional information regarding the employee's limitations:

_____

Recommended Workplace Accommodations

Please indicate your recommendations for limitations, modifications, or adjustments to the employee's job duties or work environment and explain how each will address the work-related limitation.

☐ Addition of room dividers, partitions, or other soundproofing or visual barriers between workspaces to reduce noise or visual distractions.

☐ Gradual return to work plan. Explain timeline and limitations: _____

☐ Provide leave. Specify recommended length of leave: _____

☐ Ergonomic Assessment	☐ Breaks
☐ Interpreter	☐ Modify job responsibilities
☐ Modify a policy	☐ Obtain a service
☐ Reader	☐ Reassign to vacant position
☐ Reduce/amplify lighting	☐ Modify a facility for accessibility
☐ Modify work schedule	☐ Modify tests and training materials
☐ Modify a design or product	☐ Reduction and/or removal of distractions in work area
☐ Reduction of workplace noise	☐ Provide product, equipment, machinery, hardware, or software
☐ Remote working	☐ Provide private offices or private space enclosures

Please add any additional information regarding accommodation options:

_____

Provide a timeline for these restrictions, modifications, or adjustments listed above.

☐ Temporary. Provide the estimated end date for restrictions: _____

☐ Expected to last longer than 6 months. Estimate date: _____

☐ Unknown. Please explain: _____

Questions or Comments

Questions or comments: _____

Section 3: Health Care Provider Information

Health Care Provider Name and Area of Practice* _____

Name of Company/Clinic* _____ Office Phone* _____

State Professional License Number* _____ Office Fax _____

Provider Signature*_____ Date*_____

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.

*Required Information