Accommodation Medical Request Form

The Accessibility and Accommodations Division (AAD) of the Office for Access and Equity is requesting your assistance in facilitating a reasonable accommodation for a University of Illinois employee who has requested a workplace accommodation. The employee listed below has informed the AAD of their diagnosis. This form is used to verify that they qualify as a person with a disability and helps the AAD determine how to best accommodate the employee, when possible. When an employee requests a workplace accommodation due to a disability or underlying medical condition, this form must be completed and signed by the current treating health care provider. **Providers: please fax documentation to the Accessibility and Accommodations Division at 217-244-9136.** If you have any questions, please contact 217-333-0885 or accessibility@illinois.edu. Employees: please upload this document to your case.

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 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 so 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.

**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 the diagnosis(es) for the above-named employee/patient:

What major life activity(s) is affected?

- [ ] Bending
- [ ] Breathing
- [ ] Caring for self
- [ ] Concentrating
- [ ] Hearing
- [ ] Interacting with others
- [ ] Learning
- [ ] Lifting
- [ ] Performing manual tasks
- [ ] Reading
- [ ] Seeing
- [ ] Sitting
- [ ] Speaking
- [ ] Standing
- [ ] Thinking
- [ ] Walking
- [ ] Working
- [ ] Other (specify): ________

___
What major bodily function(s) is/are affected?

- Bladder
- Digestive
- Lymphatic
- Reproductive
- Bowel
- Endocrine
- Musculoskeletal
- Respiratory
- Brain
- Genitourinary
- Neurological
- Special sense organs & skin
- Cardiovascular
- Hemic
- Normal cell growth
- Circulatory
- Immune
- Organ transplant
- Other (specify): ______________________

Please add any additional information regarding the employee’s diagnosis(es): ________________________________

### Workplace Accommodation Determination

How does the employee’s underlying medical condition or limitation(s) interfere with their ability to perform the job function(s) or access a benefit of employment?

__________________________________________________________________________________________

### 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
- Interpreter
- Modify a policy
- Reader
- Reduce/amplify lighting
- Modify a work schedule
- Modify a design or product
- Reduction of workplace noise
- Remote working
- Breaks
- Modify job responsibilities
- Obtain a service
- Reassign to vacant position
- Modify a facility for accessibility
- Modify tests and training materials
- Reduction and/or removal of distractions in work area
- Provide product, equipment, machinery, hardware, or software
- Provide private offices or private space enclosures
Please add any additional information regarding accommodation options:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Length of Accommodation Need Provide a timeline for these restrictions, modifications, or adjustments listed above:

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

☐ Permanent/expected to last longer than 6 months: Estimate end 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* ____________________________

*required information