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 an 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 accessandequity@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 major 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 Full Name _____ Employee DOB _____ Employee UIN _____

Job Title _____ Department _____

Summary of Job Duties or Copy of Job Description _____

Section 2: Completed By the Health Care Provider

A. 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) (includes major bodily functions) is/are affected?

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

Major bodily functions:

- ☐ Bladder
- ☐ Bowel
- ☐ Brain
- ☐ Cardiovascular
- ☐ Circulatory
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinay
- ☐ Hemic
- ☐ Immune
- ☐ Lymphatic
- ☐ Musculoskeletal

- ☐ Neurological
- ☐ Normal Cell Growth
- ☐ Organ Transplant
- ☐ Reproductive
- ☐ Respiratory
- ☐ Special Sense Organs & Skin
- ☐ Other: (describe)

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

_____
_____
_____
_____

B. Questions to help determine whether an accommodation is needed

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

Major bodily functions:

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- ☐ Immune
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Normal Cell Growth
- ☐ Organ Transplant
- ☐ Reproductive
- ☐ Respiratory
- ☐ Special Sense Organs & Skin
- ☐ Other: (describe)

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

_____
_____
_____

C. Questions to help determine effective accommodation options.

Please describe 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
- ☐ Breaks
- ☐ Ergonomic Assessment
- ☐ Gradual return to work plan (explain the timeline and limitations)
- ☐ Interpreter
- ☐ Modify job responsibilities
- ☐ Modify a policy
- ☐ Provide leave (specify recommended length of leave)

- ☐ Modify a facility for accessibility
- ☐ Modify or design a product
- ☐ Modify tests and training materials
- ☐ Modify work schedule
- ☐ Private offices or private space enclosures
- ☐ Provide a product, equipment, machinery or software
- ☐ Obtain a service
- ☐ Other
- ☐ Reader
- ☐ Reassign to a vacant position
- ☐ Reduce/amplify lighting
- ☐ Reduction and/or removal of distractions in the work area
- ☐ Reduction of workplace noise
- ☐ Remote working

Please add any additional information regarding accommodation options.

_____

_____

_____

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

☐ Temporary (please provide the estimated end date for restrictions): _____

☐ Expected to last longer than 6 months:_____ ☐ Unknown: _____

D. Other questions or comments.

_____

_____

Section 3: Health Care Provider Information

_____
Health Care Provider Name/Area of Practice*

_____ _____
Name of Company* State Professional License Number*

_____ _____
Phone* Fax

_____ _____
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.

* Information Required