Accommodation Medical Request Form

The Accessibility and Accommodations Division (AAD) is requesting your assistance in facilitating a reasonable accommodation for a University of Illinois employee who has requested a workplace accommodation. 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 treating health care provider most familiar with the employee's medical condition. If this form is not completed by the treating provider, the employee may submit appropriate medical documentation to support their request that provides 1) the employee's medical diagnosis(es), 2) limitations imposed by the diagnosis(es), 3) recommended accommodation(s), and 4) the length of time for the recommended accommodations to be put into place.

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.

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:

_____

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

☐ Yes ☐ No

What major life activity(s) is affected?

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

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 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 ☐ 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 a 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:

_____

_____

Length of Disability 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

Health Care Providers: please fax documentation to the AAD 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 at illinois-accommodate.symplicity.com.