

CONFIDENTIAL

All information shared with the University through the ADA/ADAAA evaluation and/or reasonable accommodation process will be maintained separate from personnel files and in accordance with all ADA/ADAAA requirements.

REASONABLE ACCOMMODATION REQUEST FORM

Individuals who are employed at the University of Tennessee Health Science Center and are requesting reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA) are encouraged to complete this form in its entirety. If you are unable to complete this form on your own, someone else may complete the form on your behalf.

Completed forms are to be returned to the Office of Access and Compliance
oac-hsc@uthsc.edu | fax (901) 488-1120 | 920 Madison, Suite 825 Memphis, TN 38163

SECTION I: EMPLOYEE INFORMATION

Name (please print)

UTHSC Email

Position Title

Department

Campus Address

Work Telephone Number (xxx) xxx-xxxx

Cell Number (xxx) xxx-xxxx

Supervisor's Name

Supervisor's Email Address

SECTION II: ACCOMMODATION INFORMATION

Please attach additional documentation if needed.

1. Identify the physical and/or mental impairment (s) for which you are requesting accommodation and the expected duration of the impairments (s). Include the date of diagnosis.

2. Explain how the impairment(s) listed above affect(s) your ability to perform the essential functions of your position. If you are a new employee, state the anticipated difficulties you foresee in

completing your essential function(s). Be as specific as possible regarding the essential function(s) you are having difficulty performing or believe you will have difficulty performing.
Note: Essential Functions are job duties that are basic or fundamental to a position.

3. List the accommodation(s) you are requesting to perform your essential job functions.
Note: Accommodation is any modification to a job, practice, policy, equipment, schedules, or the work environment that allows an individual with a disability to participate equally in an employment opportunity.

4. Add any comments you feel may be helpful in our consideration of your request.

5. Medical Verification of the impairment(s) (check the appropriate box):
 - I have enclosed the applicable medical documents with this request. (Section IV)
 - The disability and need for a reasonable accommodation are obvious and no medical documentation is needed.Explain: _____

SECTION III: SIGNATURE

I understand that this request does not entitle me to the accommodation I am seeking but will be helpful in determining the accommodation which best assists me and the agency. I understand that I may be required to provide additional documentation about the basis for my request and the requested accommodation(s). I further understand that the agency will maintain and use this information solely in evaluating my request.

Signature

Date

SECTION IV: MEDICAL INQUIRY FORM (TO BE COMPLETED BY PHYSICIAN)

**MEDICAL INQUIRY FORM IN
RESPONSE TO AN ACCOMMODATION REQUEST**

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Patient Name: _____

A. Questions to help determine whether an employee has a disability.

For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability:

Does the employee have a physical or mental impairment? Yes No

If yes, what is the impairment or the nature of the impairment? _____

Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population? Yes No

Note: Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.

OR

Describe the employee's limitations when the impairment is active.

If yes, what major life activity(s) (includes major bodily functions) is/are affected?

- | | | | | |
|--|--|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Hearing | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Interacting With Others | <input type="checkbox"/> Reading | <input type="checkbox"/> Standing | _____ |
| <input type="checkbox"/> Caring For Self | <input type="checkbox"/> Learning | <input type="checkbox"/> Seeing | <input type="checkbox"/> Thinking | _____ |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | _____ |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Performing Manual Task | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working | _____ |

Major bodily functions:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Digestive | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Special Sense Organs & Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hemic | <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Circulatory | <input type="checkbox"/> Immune | <input type="checkbox"/> Operation of an Organ | _____ |

B. Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with job performance or accessing a benefit of employment?

What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?

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

C. Questions to help determine effective accommodation options.

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

How would your suggestions improve the employee's job performance?

D. Other questions or comments.

E. Signature

Medical Professional's Name and Signature

Date

Medical Professional's Contact Information

Clinic Name