

CONFIDENTIAL

WORKPLACE ACCOMMODATION MEDICAL FORM

A. To be filled out by applicant or employee.

I authorize my medical provider(s) _____ to complete section B (below) based on information from my patient file and forward to the ADA Resource Center for the purpose of determining the appropriate job accommodations.

Signature: _____ Printed Name: _____ Date: _____

Medical Provider: To determine whether this employee is eligible under the Americans with Disabilities Act to request a workplace accommodation the University of Kansas ADA Resource Center requires verification of the employee's medical condition/ diagnosis and/ or disability. This form can be returned to the employee or faxed to (785)-864-5790. If you have any questions, please contact our office at 785-864-4946 or accessibility@ku.edu.

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.

B. To be filled out by treating healthcare practitioner:

1. Please describe the employee's medical condition, diagnosis and/or disability:

2. How does the employee's medical condition, diagnosis and/or disability impact the individual?

3. Does the medical condition substantially limit one or more of the individual’s major life activities? **(Yes or No)** **The impairment does not need to significantly or severely restrict the person’s activities to meet the standard of being substantially limiting.*
If yes, how?

4. What is the expected duration and frequency (if applicable) of the employee’s medical condition, diagnosis and/or disability? If permanent, please indicate permanent.

5. Based upon the employee’s medical condition, diagnosis and/or disability what workplace accommodation(s), are you recommending for this employee to be able to perform their job duties?

- a. Why are you recommending the above accommodation(s)?

- b. If the accommodation is for leave, what is the expected return to work date?

- c. If the suggested accommodation is not permanent, what is the likely duration of the accommodation? If permanent, state permanent.

- d. If the suggested accommodation is for an Emotional Support Animal (ESA), how does the ESA mitigate the symptoms of the medical condition/disability?

- d2. Is it necessary for the patient to live with their ESA in order to create equal enjoyment of their dwelling?

6. Could the employee’s medical condition, diagnosis and/or disability be considered a direct threat to others or is the patient taking medications or treatments that would be expected to affect job performance, which would pose a direct threat or safety risk?

Yes _____ No _____

If yes, please explain _____

****COVID SPECIFIC QUESTIONS BELOW****

a. What is your medical recommendation regarding work accommodations for your patient to perform their job duties?

b. If your medical recommendation is for your patient to telework during COVID-19 due to underlying health condition(s) mentioned in the above questions, please describe any accommodations that would permit your patient to work in-person. If none, please state none.

Please Sign before returning:

Health Care Provider Name (printed): _____

Telephone Number: _____ **Fax:** _____

Address: _____

(City) (State) (Zip)

Health Care Provider Signature: _____ **Date:** _____

If you have questions about the legal terms of this form, please call 785-864-4946

Please fax this form to 785-864-5790, with

CONFIDENTIAL: Attention ADA Office in HR on the cover page.

The University of Kansas -1246 West Campus Road - Lawrence, KS, 66045