CONFIDENTIAL
Accommodation Request Form

The purpose of this form is to assist the Medical Center in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of his/her job safely and effectively. This form will be kept separately from the employee's personnel file and be treated confidentially.

To be completed by Employee requesting accommodation:

Employee Information

Last Name:	**First Name:**	**MI:**	**EE#:**
Department Name:	**Manager Name:**		
Home Address:	**City:**	**State:**	**Zip:**
Home Email:	**Home Phone:**		
Work Email:	**Work Phone:**		

Please answer the following questions to assist us in understanding the basis and nature of your request for an accommodation (attach additional sheets if necessary). Medical documentation to support your request is required unless you are advised otherwise.

A. Please describe as completely and specifically as possible the accommodation(s) you are requesting for your disability. This could include a request for a job protected leave of absence.

_____

_____

_____

B. What are the limitations caused by your condition(s) that you are currently experiencing? Please provide as much detail as you believe is relevant.

_____

_____

_____

C. Regarding the limitations you noted above, what specific parts of your assigned responsibilities are you unable to perform because of your condition?

_____

_____

_____

D. In order to facilitate our discussions to identify an effective accommodation, tell us what changes are needed related to your job responsibilities, or the manner in which you currently carry out your responsibilities, to make it possible for you to continue to perform the essential functions of your position. Please indicate the duration of the requested accommodation, or state if it is indefinite.

_____

_____

_____

Employee's signature **Date**

Forms to be returned:

Via mail to:

Human Resources, Absence Management
The University of Chicago Medicine
5841 S. Maryland Ave. | MC 1086 | Chicago, IL | 60637-1470

Via Email to:

ADA Coordinator
Human Resources, Absence Management
Email: HRServices@uchospitals.edu

The University of Chicago Medical Center's Contact:

Manager, Absence Management
Human Resources, Absence Management
The University of Chicago Medicine
5841 S. Maryland Ave. | MC 1086 | Chicago, IL | 60637-1470
Phone: 773.702.2355 | Fax: 773. 702.0265
Email: HRServices@uchospitals.edu

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. By signing this form, I authorize the release of the following described medical information by any physician, health care provider, hospital or medical facility to the ADA Coordinator, HR Employee & Labor Relations at The University of Chicago Medical Center ("the Medical Center"), who will share this information only on a need to know basis for the purpose of determining possible accommodations.

2. This authorization is limited to information regarding any physical or mental limitation(s) I may have which may affect my ability to perform work at the Medical Center. Specifically, I authorize any physician, health care provider, hospital or medical facility to consult with the ADA Coordinator, HR Employee & Labor Relations and release any medical information concerning the extent to which my medical condition (or conditions) constitutes a disability, my ability to perform work, and my eligibility for consideration for possible reasonable accommodation.

3. The Medical Center will use this information to determine the extent to which my medical condition (or conditions) constitutes a disability, my ability to perform work, and whether any accommodations are required.

4. This authorization shall be effective as of the date of my signature and shall continue in full force and effect for one year thereafter, unless I revoke it in writing. I acknowledge that I have a right to receive a true copy of this authorization from the ADA Coordinator at the Medical Center.

Dated: _____

By: _____

Employee Signature

_____

Employee Name (print)

This section to be completed by physician or health care provider:

TO HEALTH CARE PROVIDER: **Please complete this certification in full.**

We are making this request pursuant to a written authorization from your patient, who is our employee. This questionnaire is part of an interactive process that is necessary in order to determine if your patient has a disability recognized under the American with Disabilities Act, and applicable state laws, and, if so, what, if any, reasonable accommodation(s) are necessary and can be made that would enable your patient to perform the essential functions of his or her job.

The Genetic 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.

1. Patient's Name (print): _____

2. Does the patient have a physical or mental impairment that substantially limits a major life activity(ies).

   ____ YES ____ NO

   If yes, please check the appropriate activities below.
   If no, then skip the remainder of this form and complete the signature and other information section at the end.

   _____caring for oneself
   _____ performing manual tasks
   _____ seeing
   _____ hearing
   _____ eating
   _____sleeping
   _____walking
   _____standing
   _____sitting
   _____reaching
   _____lifting
   _____bending
   _____speaking
   _____breathing
   _____learning
   _____reading
   _____concentrating
   _____thinking
   _____communicating
   _____interacting with others
   _____working
   _____ other (please specify_____

3. If the answer to Question 2 is yes, for each major life activity identified, please describe how the patient is limited.

_____

_____

_____

4. If the answer to Question 2 is yes, for how long will the patient be limited in the life activity(ies)?

_____

_____

_____

5. Do you consider the patient's condition to be temporary or non-chronic?

____ YES ____ NO

6. Is the patient unable to perform one or more of the essential functions of his/her position as a result of the condition, disorder, etc. (Please refer to the job description or other information provided by the employer regarding the essential functions of the patient's job)?

____ YES ____ NO

7. If the answer to Question 6 is "YES," please describe the essential function(s) the patient is unable to perform.

_____

_____

_____

8. If the answer to Question 6 is "YES," do you know of any modification or other accommodation that would enable the patient to perform the affected essential functions of the job?

____ YES ____ NO

9. If the answer to Question 8 is "YES," please describe in detail the suggested job modification(s) or other work accommodation(s) and the manner by which it would enable your patient to perform the affected essential job functions.

_____

_____

_____

10. Does the patient need a leave of absence because of his/her condition, disorder, etc.?

____ YES ____ NO

11. If the answer to Question 10 is "YES," for how long will the patient need to be off work (even if only your best estimate)?

_____

_____

_____

CERTIFICATION OF PHYSICIAN/HEALTH CARE PROVIDER

I hereby certify that all of the foregoing information is true and correct.

Signature of Provider: _____

Printed Name of Provider: _____

Date Signed: _____

Address of Provider: _____

_____

Telephone Number of Provider: _____

Licenses and Specialties of Provider: _____

_____

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