ADA REASONABLE ACCOMMODATIONS FORM

Medical Inquiry and Release Waiver Form to Confirm Disability and Need for Accommodation Under The Americans with Disabilities Act (ADA)

Please return form to HR Compliance

Mailing Address: 2801 W. Bancroft St., Mail Stop 205 - Toledo, OH 43606-3390

Phone: (419)530-1494 Fax: (419)530-1493

This section should be completed by the employee:

Employee Name: ______________________ Rocket ID: ____________________ Phone: ______________

Department: __________________________ Job Title: ____________________ Shift: _______________

Work Schedule: _______________________ Supervisor: ___________________ Campus: MC ☐ HSC ☐

Currently on Leave of Absence: Yes ☐ No ☐ Return to Work Date: ______________________________

Impairment identified by employee: ____

I have included a copy of my job description for my provider's review: Yes ☐ No ☐

I, ____________________________________, am requesting reasonable accommodations for my functional limitations through my employer, The University of Toledo. I give a representative of the Office of Human Resources permission to speak with and/or request written information regarding medical assessment(s) on my behalf. I authorize my health care provider to release relevant information regarding my functional limitations of my medical condition and my need for reasonable accommodation. I realize that this information will be kept in confidence and will be used only for purposes of approval of reasonable accommodations under the Americans with Disabilities Act (ADA).

Employee Signature: ____________________________________ Date: ________________________

Important: The remaining sections of this form are to be completed and signed only by the employee's Health Care Provider to confirm the need for a reasonable workplace accommodation due to a qualifying disability. This information will be reviewed to identify appropriate reasonable accommodations that do not cause an undue hardship on operations.

Information to Determine Existence of Disability

1. Does the individual have a record of a physical or mental impairment? ☐ **Yes** ☐ **No**

If yes, please identify and describe the physical or mental impairment (including the nature, symptoms, treatment plan, and severity of the impairment):

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2. **What is the duration of the physical or mental impairment?**

☐ **Temporary:**
- If temporary, please provide the estimated end date of the impairment: ____________

☐ **Indefinite/Lifelong:** (expected to last longer than 6 months)
☐ **Intermittent**, describe the frequency, duration, and severity of the impairment during a flare:
Frequency: ____
Duration: ____
Severity: ____

☐ **Unknown:** (please explain) ____

3. **Does the impairment affect one or more major life activities?** ☐ **Yes** ☐ **No**

a. If yes, what major life activity/activities is/are impaired?

Mechanical Activities

☐ Sitting ☐ Reaching ☐ Caring for Self
☐ Standing ☐ Grasping/Gripping ☐ Driving
☐ Walking ☐ Lifting ☐ Working
☐ Bending ☐ Performing Manual Tasks

Bodily Activities

☐ Sleeping ☐ Toileting
☐ Breathing ☐ Reproduction

Sensory Activities

☐ Hearing
☐ Seeing

Executive Activities

☐ Thinking ☐ Learning ☐ Interacting with others
☐ Concentrating ☐ Speaking

Other Activities (please describe)

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b. Please briefly describe the extent to which the impairments limit the patient's activities (for example: how many minutes per hour; frequency, weight restrictions, etc.):

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c. Please estimate how long each activity identified above will be restricted:

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4. **Have you reviewed a copy of the job description?** ☐ **Yes** ☐ **No**
   Does this individual have difficulty performing a job function? ☐ **Yes** ☐ **No**

If yes, please explain specifically which job duty or procedure and if this is a new employee, state the anticipated difficulties he/she foresees in completing the required job duties. Be as specific as possible regarding the job duties they will have difficulty performing:

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5. **What physical or mental limitations, if any, is interfering with the individual's ability to perform the employee's job functions or access an employment benefit?**

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6. **Please suggest the possible workplace accommodation(s) you believe will help with the physical or mental restrictions identified above:**

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7. **How would any suggested accommodation help this individual perform the individual's job functions or access an employment benefit?**

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8. **Do you anticipate that the patient will be unable to work for a continuous period? If yes, please describe the anticipate duration and frequency of the absence(s):**

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Safe Harbor Provision Under GINA

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.

Provider Name (print): ___________________________________

Provider Signature: ______________________________________ Date: ______________________________

Provider Practice/Specialty: _______________________________

Provider Phone Number: ________________________________

Address: ____

For verification of signature, please attach a stationery with your letterhead and/or other verifiable document. Thank you.

Please return form to:

Mailing Address:

The University of Toledo
HR Compliance

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Toledo, OH 43606-3390

Fax: (419) 530-1493

Email: hrcompliance@utoledo.edu