ADA REASONABLE ACCOMMODATION FORM

Medical Inquiry Form to Confirm Disability or COVID-19 At-Risk Status and Need for Accommodations Under The Americans with Disabilities Act (ADA)

Please return form to the Office of Equal Opportunity and Affirmative Action

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

Phone: 419.530.1464 Fax: 419.530.1490

Employee name:_____ Rocket ID: _____ Department: _____

Job Title: _____ Shift & Work Schedule: _____ Campus: ☐ HSC ☐ MC

Phone: _____ Impairment identified by employee: _____

Return to Work 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.

Is the medical impairment related to a COVID-19 high risk category: Yes ☐ No ☐ I'm not sure ☐

If Yes, please list the specific COVID-19 At-Risk Category: _____ (Ex. Asthma; Immunocompromised; etc.)

Is the employee requesting a Facial Covering Waiver? Yes ☐ No ☐ If Yes, please select the reason for Face Covering Waiver below:

☐ Health related ☐ Against industry best practices ☐ Prohibited by law or regulation ☐ Violates safety policy

Information to Determine Existence of Disability

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):

_____

_____

What is the duration of the physical or mental impairment?

Temporary: _____
Indefinite/Lifelong (expected to last longer than 6 months):_____
Unknown:_____

If temporary, please provide the estimated end date of the restrictions: _____

Do you define your patient's condition as qualifying under the ADA? Yes ☐ No ☐
(Under the ADA, a disability is a mental or physical condition that substantially limits a major life activity compared to most people. "Substantial" in this context means that in your professional opinion there is a notable, significant, limitation to the manner or duration in which the individual engages in the activity. Major life activities include, but are not limited to, caring for oneself, seeing, hearing, eating, speaking, walking, bending, lifting, thinking, or communicating).

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:

_____

_____

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?

_____

_____

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

_____

_____

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

_____

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: _____

Provider Practice/Specialty: _____

Provider Phone Number: _____ Address: _____

Date: _____

Please return form to:

Mailing Address:
The University of Toledo
Human Resources
Office of Equal Opportunity and Affirmative Action
2801 W. Bancroft St., Mail Stop 205
Toledo, OH 43606-3390

Fax: 419.530.1490