Accommodation Medical Request Form

The ADA Team is requesting your assistance in facilitating a reasonable accommodation for a University of Michigan employee who has requested a workplace accommodation. This form is used to verify that they qualify as a person with a disability and helps the team determine how to best accommodate the employee, when possible. When an employee requests a workplace accommodation due to a disability or underlying medical condition, the University of Michigan, as the employer, may request this form to be completed and signed by the treating healthcare provider most familiar with the employee's medical condition. If this form is not completed by the treating provider, the employee may submit appropriate medical documentation to support their request that provides 1) the employee's medical diagnosis(es), 2) limitations imposed by the diagnosis(es), 3) recommended accommodation(s), and 4) the length of time for the recommended accommodations to be put into place.

Section 1: Completed by Employee

Employee Name: _____ DOB: _____

Job Title: _____ Department: _____

Summary of Primary Job Duties: _____

_____

Section 2: Completed by Health Care Provider

Please identify the diagnosis(es) for the above-named requestor:

_____

_____

Does the diagnosis(es) limit a major life activity (listed below) compared to most people in the general population?

■Yes ☐No

What major life activity(ies) are affected:

☐Bending ☐Working ☐Reading ☐Thinking ☐Interacting with others

☐Breathing ☐Eating ☐Seeing ☐Walking ☐Performing manual tasks

☐Lifting ☐Standing ☐Learning ☐Reaching ☐Concentrating

☐Hearing ☐Speaking ☐Sitting ☐Caring for self

☐Other _____

What major bodily function(s) is/are affected

☐Bladder	☐Digestive	☐Lymphatic	☐Reproductive
☐Endocrine	☐Brain	☐Genitourinary	☐Musculoskeletal
☐Respiratory	☐Hemic	☐Bowel	☐Neurological
☐ Immune	☐Cardiovascular	☐Circulatory	☐ Normal cell growth
☐Special sense organs & skin		☐Organ Transplant	
☐ Other_____			

Please add any additional information regarding the employee's diagnosis:

_____

_____

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

_____

_____

Recommended Workplace Accommodations:

Please provide any recommendations for addressing the limitations experienced by the employee, or potential modifications or adjustments to the job duties or work environment of the employee.

☐Addition of room dividers, partitions, or other soundproofing or visual barriers between workspaces to reduce noise or visual distractions.

☐Gradual return to work plan. Explain timeline and limitations: _____

_____

☐Provide leave. Specify frequency and length: _____

☐Ergonomic equipment	☐Breaks
☐ ASL Interpreter or CART services	☐Modify a policy

☐Flexible start/end time ☐Assistive technologies (software, readers etc.)

☐Reduce/Amplify/Change lighting ☐Modify a facility for accessibility

☐Modify work schedule ☐Modify tests or training materials

☐Modify job responsibilities ☐Reduction/removal of distractions in area

☐Provide product, equipment, or hardware (noise machine, recorder, larger monitors)

☐Provide private office space or private space enclosure

☐Other: _____

_____

Timeline for restrictions, limitations, modifications, and adjustments:

☐Temporary. Provide the estimated end date for restrictions: _____

☐Permanent/expected to last more than 6 (six) months.

☐Unknown. Please explain: _____

Section 3: Health Care Provider Information

Provider Name and Area of Practice: _____

Name of Clinic/Medical Group: _____

Office Phone: _____ State Professional License No. _____

Provider Signature: _____ Date: _____

Providers: Please submit this form by email to: ecrt-adateam@umich.edu.

Employees: Please upload the completed document into your Accommodate case file at https://ecrt-umich-accommodate.symplicity.com/.

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.