EMPLOYEE ACCOMMODATION REQUEST FORM
Request for Reasonable Accommodation

Instructions for Section I

The Employee Relations and Compliance office in Human Resources is responsible for monitoring and addressing compliance with the Americans with Disabilities Act as well as Section 503 of the Rehabilitation Act of 1973. Please fully answer each item in Section I, then provide the form along with a copy of your job description, to your healthcare provider to complete Section II. Forward completed forms and attachments to Employee Relations, Human Resources, Cardinal Station, 215 Central Ave., suite 205, Louisville, Kentucky 40208, to emrelate@louisville.edu, or fax completed forms to 502-852-5665.

ADA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support an accommodation(s). Failure to provide a complete and sufficient medical certification will result in a denial of your request. **Requests for information must be fulfilled within fifteen (15) calendar days.**

Section I: for Completion by Employee

Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Home/Mobile Phone: _____

Work Phone: _____ Department: _____

Job Title: _____ Employee ID: _____

Supervisor's Name: _____ Supervisor's Phone Number: _____

Describe your current job duties requiring an accommodation because of a disability:

Describe the functional limitations caused by your disability for which you are requesting an accommodation. Use additional pages, if necessary. (Attach any additional medical documentation):

Describe any accommodation(s) you believe would minimize or eliminate the functional limitations listed above. Include any available information relating to source, name of device, etc. Use additional pages, if necessary:

AUTHORIZATION

I have voluntarily completed this Employee Accommodation Request Form and all information provided is true and accurate to the best of my knowledge or belief. I give UofL permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate University personnel and/or my health care professional, and acknowledge that such communication is job-related and consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I may be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.

Print Name of Employee: _____

Signature of Employee: _____ Date: _____

Instructions for Section II

Once you have completed section I, please submit section II to your healthcare provider for completion, along with section I and your job description. Once your healthcare provider has completed section II, please submit both sections to the Human Resources address above.

Section II: for Completion by Healthcare Provider

Instructions for Section II: Please fully answer all applicable parts, based on your medical knowledge, experience, and examination of the patient. The employee should provide you with a copy of their job description. Please refer to the following sections of the job description when completing this form: job duties, physical effort, and essential functions. Please attach additional pages if more space is needed.

Healthcare Provider's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Employee (Patient) Name: _____

Does this employee have a physical or mental impairment?

☐ Yes ☐ No

If yes, state the type of impairment:

Level of impairment: Mild ☐ Modest ☐ Severe ☐

What major life activities are affected?

☐Bending ☐Breathing ☐Caring For Self ☐Concentrating ☐Eating ☐Hearing ☐Interacting With Others ☐Learning ☐Lifting ☐Performing Manual Tasks ☐Reaching ☐Reading ☐Seeing ☐Sitting ☐Sleeping ☐Speaking ☐Standing ☐Thinking ☐Walking ☐Working ☐Other: (describe)

What (if any) major bodily functions are affected?

☐Bladder ☐Bowel ☐Brain ☐Cardiovascular ☐Circulatory ☐Digestive ☐Endocrine ☐Genitourinary ☐Hemic ☐Immune ☐Lymphatic ☐Musculoskeletal ☐Neurological ☐Normal Cell Growth ☐Operation of an Organ ☐Reproductive ☐Respiratory ☐Special Sense Organs & Skin ☐Other: (describe)

What is the duration or expected duration of the employee's impairment?

Can the employee perform all job duties listed in the job description?

☐ Yes ☐ No

If no, state which job functions cannot be performed and why:

Describe any reasonable accommodations that would allow the employee to perform the job functions listed above (if medical leave is one of the possible accommodations, please provide an estimated duration for the leave):

Would performing any job function listed in the job description result in a direct safety or health threat to the employee or other people (coworkers, the general public, etc.)?

☐ Yes ☐ No

If yes, state which job functions would pose a threat, what that threat could be, and any reasonable accommodation that would eliminate or reduce the threat to an acceptable level:

Signature of Healthcare Provider: _____ Date: _____

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.