Medical Request for ADA Accommodations

Name of Employee _____ Date _____

Contact Information

Name _____ **Title** _____

Name of Practice (if applicable) _____

Mailing Address _____
Street Address

_____
City **State** **Zip Code**

Phone Number (_____) _____ **Fax Number** (____) _____

You have been identified as the above listed employee's primary practitioner in which to consult regarding a medical condition that may require an accommodation in the workplace. In order for Albany State University to proceed, we require information about the employee's medical condition from a licensed health practitioner. Enclosed is a copy of the *Health Information Release Waiver* form submitted by the employee authorizing a Human Resources Department representative to seek personal health information relating to any relevant medical condition(s).

The Americans with Disabilities Act requires employers to provide reasonable accommodations to employees who are disabled, i.e., have a medical condition that substantially limits a major life function. We are requesting that you complete the attached form to determine if the employee is covered under the ADA, and if so, the nature of the condition and which major life activities it substantially limits. In addition, please advise us regarding what accommodations, if any, you believe the employee needs in order for him/her to perform his/her job duties and responsibilities. Enclosed is a copy of the employee's job description. The employee has been asked to provide guidance as to what accommodations may be necessary.

After you have completed the medical documentation, please fax documents to (229) 438-4802 or mail to the following address:

Albany State University
504 College Drive
Human Resources, BCB 382
ATTN: Kimberly Carter
Albany, GA 31705
If you have any questions, please contact Kimberly Carter at (229) 430-4263.

For Internal Use Only:
Date submitted to Physician's Office Submitted by:
Submitted via: □ Fax Number □ Mail
Enclosed documents: □ Waiver of Information Form □ Job Description

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1. What is the nature of the illness/condition? (If additional space is needed, please use the back of this form).

2. Check all major life functions that are limited as a result of illness/condition. Major life functions include, but are not limited to the following:

☐ Caring for oneself	☐ Walking	☐ Seeing	☐ Hearing	☐ Speaking
☐ Performing manual tasks	☐ Breathing	☐ Learning	☐ Working	☐ Sitting
☐ Interacting with others	☐ Standing	☐ Lifting	☐ Thinking	☐ Concentrating

☐ Other(s) _____

3. How does the illness/condition affect each major life function checked above? (Provide an explanation for each major life function checked above). To what extend does the illness/condition limit the major life functions above? (Be specific).

4. How long do you anticipate these accommodations to be required?

Practitioner's Signature _____ **Date Completed** _____

Thanks for your assistance.