# OFFICE OF HUMAN RESOURCES MANAGEMENT

## ADA (Americans with Disabilities Act)
## Request for Information from Medical Provider
## MEDICAL STATUS EVALUATION Form

_________________________________________________, who is an employee of Albany State University, has requested a reasonable accommodation under the Americans with Disabilities Act (ADA). In response to that request, we are seeking specific information as detailed below. Please refer to the attached description of the employee's job that contains a list of essential job functions and provide the requested information only – **please do not send copies of medical records.**

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.

**Note:** The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities.

1. In your professional judgment, does this individual have a *physical impairment* that "is a Physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems

   Does the employee have a physical or mental impairment?

   a) neurological
   b) musculoskeletal
   c) special sense organs
   d) respiratory (including speech organs)
   e) cardiovascular
   f) reproductive
   g) digestive
   h) genitor-urinary
   i) hemic and lymphatic
   j) skin
   k) endocrine

   ❒ Yes ❒ No

2. If yes, please explain the impairment below?

   ______________________________________________________________________________

   ______________________________________________________________________________

   ______________________________________________________________________________



**Albany State University is an equal opportunity employer. As such, the University takes affirmative action to include discrimination in recruiting, transferring, training and terminating of employees because of race, color, creed, age, sex, national origin, veteran status, or any other reason with applicable state and federal status, executive orders and other regulations which prohibits discriminatory employment practices.**

3. What is the expected duration of the impairment?

   ❒ Permanent

   ❒ Temporary (please explain)

   ______________________________________________________________________________

   ❒ Chronic (please explain)

   ______________________________________________________________________________

   ❒ Episodic (please explain)

   ______________________________________________________________________________

4. Does the impairment affect or limit one or more major life activities?

   (Examples of major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and the operation of a major bodily function such as the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive systems).

   ❒ Yes ❒ No

5. According to ADA regulations, the limitation to major life activities must be substantial, meaning "an individual must be unable to perform, or be significantly in the ability to perform, the function". Three factors in determining if a person's has an impairment that limits a major life activity is:

   a. Severity of the impairment
   b. Duration of the impairment
   c. Long-term or anticipated impact of the impairment

   Is the individual's impairment in your professional judgment "substantial"?

   ❒ Yes ❒ No

6. What limitation(s) interfere with the employee's ability to perform the essential functions? How does the limitation(s) interfere with the employee's ability to perform the job functions?
   NOTE: Complete "Estimated Functional Capacity Evaluation" for positions requiring physical/manual labor.

   ______________________________________________________________________________

   ______________________________________________________________________________



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7. Do you have any suggestions for adjustments to the work environment that would enable the employee to perform the essential functions? Please describe:

______________________________________________________________________________

______________________________________________________________________________

8. How would your suggested adjustments enable the employee to perform the essential functions?

______________________________________________________________________________

______________________________________________________________________________

9. Attendance and working regularly is crucial and is a condition of employment. Does this medical condition prevent the person from being able to report to work in any way?

❒ Yes ❒ No

If yes, what is the expected time frame that this individual is anticipated to be absent from work?

☐ Monday ___________ a.m. to ________ p.m.
☐ Tuesday ___________ a.m. to ________ p.m.
☐ Wednesday ___________ a.m. to ________ p.m.
☐ Thursday ___________ a.m. to ________ p.m.
☐ Friday ___________ a.m. to ________ p.m.
☐ Saturday ___________ a.m. to ________ p.m.
☐ Sunday ___________ a.m. to ________ p.m.

10. Additional comments or suggestions:

______________________________________________________________________________

______________________________________________________________________________

Signature of healthcare professional: ____________________________________ Date: ______________

**Return form to:**

Albany State University
Office of Human Resources, Benefits Department
504 College Drive
Billy C. Black Building, Room 382
Albany, Georgia 31705

Contact Information:
Tel: 229.430-4623
Fax: 229.430-2867

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