REQUEST FOR WORK ACCOMMODATIONS

Section 1: To be completed by the employee.

Name	A#
Job Title	Department
Work Schedule	Preferred Phone Number
Primary Job Duties	

I authorize Dr. _____ to discuss my medical case history, specifically as it relates to my ability to perform the essential functions of my job, with an authorized representative of UAH Human Resources in order to assess the need for a reasonable workplace accommodation, if necessary.

_____

Employee Signature

Section 2: To be completed by the healthcare provider.

Dear Healthcare Provider,

A request for a reasonable accommodation has been made by the employee listed above, who is also a patient under your care. In order to support an interactive process of review, we are requesting you to provide feedback to the following questions based on your medical expertise. ***Once completed, this form may be returned directly to the employee/patient for submission to the University of Alabama in Huntsville.***

Please note that according to the Americans with Disabilities Amendments Act (ADAA), an employee has a disability if s/he has an impairment that substantially limits one or more major life activities or a record of such an impairment. Examples of "major life activities" includes caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions. Thank you.

Please answer these questions to help determine disability and reasonable accommodation.

1) Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?

   ☐ YES ☐ NO (If YES, please continue to next question.)

   If NO, how long will the employee be unable to perform these job duties?

   _____# of weeks_____# of months_____permanently

2) Does the employee have a physical or mental impairment? ☐ YES ☐ NO
   If YES, what is the impairment?

3) What limitation(s) is interfering with job performance, and how does it interfere with the employee's ability to perform the job function(s)?

4) What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

5) What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?

6) How would your suggestions improve the employee's job performance?

7) How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically re-evaluated?

8) Any additional comments or suggestions:

_____

Name of Healthcare Provider (Please Print)

_____

Signature of Healthcare Provider

_____

Date