ADA REQUEST FOR REASONABLE ACCOMMODATIONS HEALTHCARE PROVIDER FORM

The employee indicated below recently requested a workplace accommodation under the provisions of the Americans with Disabilities Act (ADA). An employee with a disability is entitled to an accommodation, unless the accommodation poses an undue hardship, but must provide current documentation of his/her disabilities. This form will help determine 1) if the employee has a disability, 2) whether an accommodation is needed, and 3) the most effective accommodation.

The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment. As the diagnosing professional, please complete all sections of this form (please print). Additional reports of information may be attached. Thank you for your assistance.

Part A. Employee Identification Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td></td>
</tr>
<tr>
<td>Job Classification/Title</td>
<td></td>
</tr>
<tr>
<td>Department</td>
<td>Division</td>
</tr>
</tbody>
</table>

Diagnosis

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

Primary Diagnosis: ________________________________________________________________

_________________________________________________________

Date of Diagnosis: __/__/____ Date of last visit: __/__/____

If the patient has an impairment, please describe the nature of the impairment: ________________________________

________________________________________________________

Is the condition persistent and long term: Yes / No

If temporary, what is the expected duration? ________________________________
Substantial Function Limitation

Which of the following major life activities and body functions are substantially limited by the impairment (check all that apply):

**MAJOR LIFE ACTIVITIES**
- [ ] Bending
- [ ] Breathing
- [ ] Caring for Self
- [ ] Concentrating
- [ ] Eating
- [ ] Other:
- [ ] Breathing
- [ ] Interacting with Others
- [ ] Learning
- [ ] Performing Manual Tasks
- [ ] Other:
- [ ] Reading
- [ ] Standing
- [ ] Seeing
- [ ] Sitting
- [ ] Speaking
- [ ] Thinking
- [ ] Walking
- [ ] Working

**MAJOR BODY FUNCTIONS**
- [ ] 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:

How does the condition affect the employee’s ability to perform essential functions of his/her job or access a benefit of employment? (a job description is attached, which lists/describes the essential functions)

________________________________________________________________________

________________________________________________________________________

Based on the employee’s limitation(s), what job function or benefits of employment is the employee having trouble performing or accessing?

________________________________________________________________________

Reasonable Accommodations

What accommodations do you recommend?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If the requested accommodation is time taken off from work, how much is recommended?

__________
Are there any activities or situations that should be avoided or that would present a significant risk, serious injury, or death for the employee? 

Other Comments

Qualifications of Certifying Provider

Name: ___________________________ Degree: ___________________________

Practice Address (or business card): _______________________________________

Phone: __________________________ Fax: __________________________ Email: __________________________

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. (EEOC).

Please return this form to Human Resources Office by mail or fax:

William & Mary
Human Resources Office
Attention: Debbie Howe
P.O. Box 8795
Williamsburg, VA 23187
(757) 221-3153
(757) 221-1739 (fax)