



**REQUEST FOR INFORMATION
REGARDING ELIGIBILITY AND NEED FOR
REASONABLE WORKPLACE ACCOMMODATIONS**

The University of Oregon has an affirmative duty and is committed to providing reasonable workplace accommodations to individuals with disabilities. We are seeking your assistance collecting information necessary to determine whether the University employee identified below – who we understand is your patient – has a medical condition that qualifies as a disability under the Americans with Disabilities Act, as amended (ADA), and what workplace accommodations, if any, you would recommend.

As you may know, the term disability is defined broadly under the ADA. The University's obligation to provide reasonable workplace accommodations extends to individuals who:

- Currently have a physical or mental impairment that substantially limits one or more major life activities; or
- Have a record of, and are still impacted by, such an impairment.

Your assistance is critical in evaluating and providing workplace accommodations. Please complete and sign this form and return a copy to Human Resources by fax at (541) 346-2548 or email at WorkplaceADA@uoregon.edu.

Please do not hesitate to contact the ADA Coordinator at (541) 346-3159 or by email at WorkplaceADA@uoregon.edu if you have any questions.

TO BE COMPLETED BY UNIVERSITY OF OREGON EMPLOYEE:

Employee/Patient Name:

Job Title and Department:

Name of Healthcare Provider:

Human Resources, ADA Coordinator

5210 University of Oregon, Eugene OR 97403-5210

T (541) 346-3159 F (541) 346-2548 hr.uoregon.edu



TO BE COMPLETED BY THE EMPLOYEE'S HEALTHCARE PROVIDER

- (1) Does the above-named individual have a physical or mental impairment that currently limits, or previously limited, their ability to perform one or more major life activities or the operation of a major bodily function? Yes ___ No ___

If yes, please identify all of the major life activities or major bodily functions affected. Major life activities include, but are not limited to: sitting, standing, lifting, walking, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, caring for oneself, performing manual tasks, interacting with others, seeing, hearing, eating and sleeping.

Please describe the nature, scope, and anticipated duration of those limitations.

- (2) In your professional opinion, is the above-named individual more limited than the average person in the general population in their ability to perform any of the major life activities or major bodily function identified in response to Question 1? Yes ___ No ___

If yes, please identify the life activities or bodily functions which are substantially limited.



- (3) Do the limitations identified in response to Question 1, if any, interfere with the employee's ability to perform the functions of their job? Yes ___ No ___

If yes, please describe how the limitations impact their ability to perform the functions of their job. A copy of the employee's job description may be provided by Human Resources upon request.

- (4) Does the above-named individual require workplace accommodations in order to effectively perform the functions of their job? Yes ___ No ___

If yes, please identify any accommodations that you would recommend the University provide so that they are able to effectively perform the functions of their position. If possible, please name several alternatives that may be effective. Please be as specific as possible.



(5) Does the above-named individual currently have a substantially limiting medical condition that requires a leave of absence from their position? Yes ___ No ___

(a) If yes, why do they need a leave of absence? (e.g., surgery and/or recovery, adjustment to a new medication regimen, doctor visits, etc.)

(b) How much leave, if any, do you anticipate they will need?

(c) Do you anticipate that they will be able to maintain regular and reliable attendance, and perform the essential functions of their position (either with or without reasonable accommodations) following a leave of absence? Yes ___ No ___

(6) Please provide any additional information that you believe is relevant to the university's assessment of whether the above-named individual's medical condition is a disability under the ADA and with respect to their request for workplace accommodations.



UNIVERSITY OF OREGON

**MEDICAL PROVIDER FORM
ACCOMMODATION (DISABILITY)**

Any information that you provide regarding your patient's underlying medical condition¹ will be collected and maintained in a confidential file separate from their personnel records and treated as a confidential medical record to the extent required by law.

While it is ultimately the University's responsibility to determine whether the medical condition is a disability or the requested accommodations are reasonable, your assistance is critical in evaluating and providing workplace accommodations.

Healthcare Provider Name (Print)

Healthcare Provider Signature

Date

¹ 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.