Medical Information Request Form

Date: __________________________

Name of Employee: __________________________________________________________________

Name and Title of Person Completing this Form: ___________________________________________

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

If yes, what is the nature and severity of the impairment?

_________________________________________________________________________________

What is your prognosis as to the duration of her/his condition?

_________________________________________________________________________________

Does the impairment substantially limit a major life activity?  ☐ Yes ☐ No

If yes, what major life activity(s) is/are limited?  ___________________________

(examples: speaking, hearing, seeing, breathing, walking, standing, sitting, sleeping, reaching, learning, concentrating, thinking, reproducing, caring for self, interacting with others, performing manual tasks)

_________________________________________________________________________________

Does the impairment substantially limit a major bodily function?  ☐ Yes ☐ No

If yes, what major bodily function(s) is/are limited?  ___________________________

(examples: circulatory, endocrine, reproduction, hemic, special sense organs and skin, lymphatic, immune, normal cell growth, digestive, neurological, brain, respiratory, bowel, bladder, genitourinary, musculoskeletal, cardiovascular)

_________________________________________________________________________________

What are the limitations/restrictions caused by the condition and/or the treatment of the condition?

_________________________________________________________________________________
Please indicate how the condition impacts his/her ability to perform the essential job functions, and how long you anticipate the condition will last.

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<th>Essential Job Function</th>
<th>Limitation/Impact</th>
<th>Anticipated Duration</th>
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What accommodation, if any, do you believe will enable the employee to perform the essential job functions?

________________________________________________________________________

Signature of Medical Professional  
Date

**Please return to:**

**For Medical Center Employees –**

Veronica Ford, Medical Center Employee Relations, Box 800567, Charlottesville, VA 22908-0567

**For University Academic Employees –**

Gary Helmuth, University Human Resources, Box 400127, Charlottesville, VA 22904-4127