**Healthcare Information Request Form**

Click or tap to enter a date.

Name of Employee Requesting an Accommodation:

The employee has requested a disability-related workplace accommodation to enable the employee’s performance of essential job functions and has identified you as the employee’s treating healthcare professional. Based on your evaluation of the employee, and your review of the employee’s essential job functions, please provide specific and detailed answers to the following questions.

# Healthcare Professional’s Contact Information

Name (please print):

Title and/or credentials:

Office Name:

Mailing Address:

City, State, and Zip Code:

Phone Number:

Email Address:

# Questions regarding the Employee Requesting a Disability-Related Workplace Accommodation

1. Does the employee currently have a physical or mental impairment? Yes [ ]  No [ ]
2. If yes, what is the nature and severity of the impairment?
3. What is your prognosis as to the duration of the employee’s condition?
4. Does the impairment substantially limit one or more major life activities? Yes [ ]  No [ ]
5. If yes, please check the major life activity or activities that are substantially limited:

| [ ]  Bending | [ ]  Breathing | [ ]  Caring for Self | [ ]  Concentrating | [ ]  Eating |
| --- | --- | --- | --- | --- |
| [ ]  Hearing | [ ]  Interacting with Others | [ ]  Learning | [ ]  Lifting | [ ]  Performing Manual Tasks |
| [ ]  Reaching | [ ]  Reading | [ ]  Seeing | [ ]  Sitting | [ ]  Sleeping |
| [ ]  Speaking | [ ]  Standing | [ ]  Thinking | [ ]  Walking | [ ]  Working |
| [ ]  Other:       |  |  |  |  |

1. Does the impairment substantially limit a major bodily function? Yes [ ]  No [ ]
2. If yes, please check the major bodily function or functions that are substantially limited:

| [ ]  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:       |  |

1. Please explain the functional limitations of the employee’s identified impairment and to what extent the employee is limited in the ability to perform essential job functions.
2. As applicable and appropriate, please suggest, on the chart below, specific workplace modifications and/or auxiliary aids or services that are necessary to enable the employee to perform the essential job functions, and to the extent possible, the anticipated duration of the accommodation indictating estimated start and end dates, including if anticipated to be permanent. If additional space is needed, please use a separate sheet of paper and attach it to this form with your signature and date.

| Essential Job Functions(FOR U.V.A. USE ONLY) | Proposed Accommodation | Duration of Accommodation |
| --- | --- | --- |
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# Healthcare Professional’s Signature and Return Information

Healthcare Professional’s Signature:

Date of Signature:

 *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers 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*.

For University Medical Center employees, please return the information requested within this letter by mail to Althea Howell, Medical Center Employee Relations, P.O. Box 800589, Charlottesville, VA 22908-0567.

For University Academic employees, please return the information requested within this letter by mail to Kimberlyn McDonald, University Academic Employee Relations, P.O Box 400127, Charlottesville, VA 22904-4127.