HEALTH INFORMATION REQUEST FORM

Date:

Name of Employee:

The employee has requested a disability-related accommodation to enable performance of essential job functions and has identified you as the 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.

Printed Name of Healthcare Professional:

Phone Number and Email Address:

Office Name and Address:

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 the employee’s condition?

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

If *yes*, please check the major life activity or activities that apply?

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

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

If yes, please check the major bodily function or functions that apply?

| Bladder | Digestive | Lymphatic | Reproductive |
| --- | --- | --- | --- |
| Bowel | Endocrine | Musculoskeletal | Respiratory |
| Brain | Genitourinary | Neurological | Special Sense Organs & Skin |
| Cardiovascular | Hemic | Normal Cell Growth | Other: (describe) |
| Circulatory | Immune | Operation of an Organ |  |

Please explain to what extent the employee is limited in the ability to perform essential job functions.

As applicable, 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 as well as, to the extent possible, the anticipated duration of the accommodation (indicating estimated start and end dates or if accommodation is 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.

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| --- | --- | --- |
| Essential Job Functions  (FOR U.V.A. USE ONLY) | Proposed Accommodation | Duration of Accommodation |
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Signature of Healthcare Professional Date

*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*.

**Please return to:**

**For Medical Center Employees:**

*Althea Howell,* Medical Center Employee Relations, P.O. Box 800567, Charlottesville, VA 22908-0567

**For University Academic Division Employees:**

*Sandy Bakoczy*, University Human Resources, P.O. Box 400127, Charlottesville, VA 22904-4127