



Medical Request for ADA Accommodations

Name of Employee _____ Date _____

Contact Information

Name _____ Title _____

Name of Practice (if applicable) _____

Mailing Address _____

Street Address

City

State

Zip Code

Phone Number (____) _____

Fax Number (____) _____

You have been identified as the above listed employee's primary practitioner in which to consult regarding a medical condition that may require an accommodation in the workplace. In order for Georgia College & State University to proceed, we require information about the employee's medical condition from a licensed health practitioner. Enclosed is a copy of the *Health Information Release Waiver* form submitted by the employee authorizing a representative of the Office of Human Resources to seek personal health information relating to any relevant medical condition(s).

The Americans with Disabilities Act requires employers to provide reasonable accommodations to employees who are disabled, i.e., have a medical condition that substantially limits a major life function. We are requesting that you complete the attached form to determine if the employee is covered under the ADA, and if so, the nature of the condition and which major life activities it substantially limits. In addition, please advise us regarding what accommodations, if any, you believe the employee needs in order for him/her to perform his/her job duties and responsibilities. Enclosed is a copy of the employee's job description. The employee has been asked to provide guidance as to what accommodations may be necessary.

After you have completed the medical documentation, please fax documents to (478) 445-0491 or mail to the following address:

Georgia College & State University
231 W. Hancock Street
Human Resources, CBX 028
ATTN: Carol A. Ward
Milledgeville, GA 31061

If you have any questions, please contact Carol Ward at (478) 445-5596.

For Internal Use Only:

Date submitted to Physician's Office _____ Submitted by: _____

Submitted via: Fax Fax Number _____ Mail

Enclosed documents: Waiver of Information Form Job Description

Medical Information Form from Health Practitioner

Name of Employee _____

Date _____

1. What is the nature of the illness/condition? (If additional space is needed, please use the back of this form). _____

2. Check all major life functions that are limited as a result of illness/condition. Major life functions include, but are not limited to the following:

- | | | | | |
|--|------------------------------------|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Caring for oneself | <input type="checkbox"/> walking | <input type="checkbox"/> seeing | <input type="checkbox"/> hearing | <input type="checkbox"/> speaking |
| <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> breathing | <input type="checkbox"/> learning | <input type="checkbox"/> working | <input type="checkbox"/> sitting |
| <input type="checkbox"/> Interacting with others | <input type="checkbox"/> standing | <input type="checkbox"/> lifting | <input type="checkbox"/> thinking | <input type="checkbox"/> concentrating |
| <input type="checkbox"/> Other(s) _____ | | | | |

3. How does the illness/condition affect each major life function checked above? (Provide an explanation for each major life function checked above). To what extent does the illness/condition limit the major life functions above? (Be specific). _____

4. How long do you anticipate these accommodations to be required? _____

Practitioner's Signature _____ Date Completed _____

Thanks for your assistance.