Texas Health Resources®

Integrated Disability Management
Reasonable Accommodation Request

Return completed form to your Entity Employee Health Department.

PART I: (To be completed by Employee)

NAME _____ DEPT _____ ENTITY _____

JOB TITLE _____ EMPLOYEE ID _____ SUPERVISOR _____

☐ FULL TIME ☐ PART TIME ☐ PRN

Contact information:

TELEPHONE _____ EMAIL _____

What are the specific job function(s) for which accommodation is being requested?

_____

_____

What functional limitation(s) (e.g. standing, walking, sitting, seeing, hearing, carrying) **is making it difficult for you to perform this/these job functions? ***
(please do not include medical diagnosis or condition**)**

_____

_____

What specific accommodation(s) are you requesting?

_____

_____

Dates in which accommodation(s) is needed
(as verified by healthcare provider): _____

I acknowledge that the information above regarding my job status and essential job function is correct to the best of my knowledge. I also acknowledge that this request for an accommodation is both reasonable and within the scope of the job tasks assigned to me.

EMPLOYEE SIGNATURE: _____ **Date** _____

*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.

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PART II: Medical Provider Inquiry Form in Response to an Accommodation Request

(To be completed by Medical Provider)

Employee Name:_____ Telephone: _____

A. **Questions to help determine the employee's specific impairments.**

In order to qualify for the benefits of the ADA, an employee must be disabled under the Act. Your answers to the following questions may help determine whether the employee has such an impairment or record thereof.*

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
   a. If yes, what is the impairment? _____
   _____
   _____
2. Is the impairment permanent? ☐ Yes ☐ No
   a. If not permanent, how long will the impairment likely last? _____

Please answer the following questions based on what limitations the employee has when his or her condition is in an active state (flare-up) and no mitigating measures are used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

3. Are there any permanent restrictions associated with the impairment? ☐ Yes ☐ No
   a. Identify each permanent restriction the employee has, and if the employee can perform the activity some, but not to the level of a normal person, identify the limits.

PERMANENT RESTRICTION (e.g., "lifting")	LIMIT EMPLOYEE CAN PERFORM THE TASK (e.g., for lifting "Up to 10 lbs.)

4. Are there any restrictions the employee has now, but that you estimate the employee will not have later? ☐ Yes ☐ No
   a. Identify each temporary restriction the employee has, how long the employee will likely have the restriction, and your level of confidence that the restriction will be removed after the date provided.

TEMPORARY RESTRICTION	Estimated Date employee will be able to perform?	Level of Confidence date is accurate
	Date: ______________ Or □ A return to work date cannot be determined at this time.	□ Not Sure □ Hopeful □ Cautiously optimistic □ Reasonably Certain □ Highly confident □ Other: Please state: ________________________ ________________________
	Date: ______________ Or □ A return to work date cannot be determined at this time.	□ Not Sure □ Hopeful □ Cautiously optimistic □ Reasonably Certain □ Highly confident □ Other: Please state: _______________________ _______________________
	Date: ______________ Or □ A return to work date cannot be determined at this time.	□ Not Sure □ Hopeful □ Cautiously optimistic □ Reasonably Certain □ Highly confident □ Other: Please state: ________________________ ________________________

5. Does the employee have flare-ups because of the impairment? ☐ Yes ☐ No
    a. If yes, please identify the frequency of the flare-ups, the duration of the flare-ups when they occur, the restrictions associated with the flare-up when they occur, and whether there is an estimated date in the future where the flare-ups will no longer occur.

Function / Restriction	Frequency of Flare-up	Duration of Flare-up	Estimated Duration this need intermittent restriction will exist

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6. After considering your answers above, does the impairment substantially limit a major life activity? ☐ Yes ☐ No
   a. If yes, what major life activity (ies) is/are affected?

☐ Caring for Self	☐ Walking	☐ Hearing	☐ Lifting
☐ Interfacing with Others	☐ Standing	☐ Seeing	☐ Sleeping
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating
☐ Breathing	☐ Thinking	☐ Learning	☐ Reproduction
☐ Working	☐ Toileting	☐ Sitting	

7. Does the impairment substantially limit the operation of a major bodily function? ☐ Yes ☐ No
   a. If yes, what bodily function(s) is/are affected?

☐ Immune	☐ Hemic	☐ Circulatory	☐ Endocrine
☐ Digestive	☐ Lymphatic	☐ Bowel	☐ Brain
☐ Bladder	☐ Reproductive	☐ Neurological	☐ Respiratory
☐ Cardiovascular	☐ Genitourinary	☐ Musculoskeletal	
☐ Normal Cell Growth	☐ Special Sense Organs & Skin		

☐ Other _____

B. **Questions to help determine whether an accommodation is needed and possible options.**

An employee with a disability may be entitled to a reasonable accommodation. Your answers to the following questions may help determine whether the requested accommodation is needed because of the disability and what accommodation may enable the employee to return to work. The employee's job description □ is □ is not attached. Additional information about the employee's job and essential functions are as follows (this list is not all inclusive; we are merely highlighting a few key ones).

_____

_____

_____

1. What restriction(s) indicated above is/are interfering with the employee's job perform or ability to perform essential job functions? (as best you understand those essential functions)

_____

_____

_____

Do you have any suggestions that would help the employee perform all essential functions, and maintain an acceptable level of productivity? If so, what are your suggestions?

_____

_____

_____

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2. Do you believe the employee is currently able to perform his/her job, with or without accommodation? ☐ Yes ☐ No

   a. If NO, do you believe the employee will be able to perform the functions ~~of his/her job in~~ the near future? ☐ Yes ☐ No

   b. If YES, when do you estimate the employee will be able to resume work?
   (please do not place the date of your next follow-up appointment here; please provide us the date you best estimate the employee will be able to resume performing all essential functions)

      ☐ I estimate the employee will be able to return on: _____

      What is your present confidence, to a reasonable degree of medical certainty, that the date you provided is accurate?

      ☐ Reasonably Certain ☐ Not Sure ☐ Hopeful ☐ Cautiously Optimistic
      ☐ Highly confident ☐ Guessing ☐ Other _____

      ☐ A return to work date cannot be determined at this time. The employee's need for leave is indefinite.

3. Is the employee generally able to work (not specifically his or her own job, but just in general) now or in the very near future? ☐ Yes ☐ No

   a. If yes, please describe when the employee could perform work and what type:

      _____

      _____

C. **Other Comments:**

D. **Medical Provider Information:**

Signature _____ **Date** _____

Medical Provider Name _____
(Please Print)

Name of Medical Practice _____

Address _____ City _____ State _____ Zip Code_____

Telephone _____ Email _____

Note: Once completed, this form may be either returned to the employee or mailed to the address below. The employee may choose either.
Entity Employee Health Department Contact: _____
Address: _____ Telephone: _____

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