



Medical Request for ADA/AA Accommodations

Name of Employee _____ Date _____

Physician's 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 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 and Employee Relations to seek personal health information relating to any relevant medical condition(s).

The Americans with Disabilities Act Amendments Act (ADAAA) requires employers to provide reasonable accommodations to employees who are disabled, i.e., have a physical or mental impairment that substantially limits one or more major life activities or have a record of such impairment. We are requesting that you complete the attached form in order to assist with determining whether the employee has a disability and which major life activities are substantially limited. 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 mail originals to the following address:

Office of Human Resources and Employee Relations
Campus Box 028
Milledgeville, GA 31061
ATTN: ADA/AA Coordinator

If you have any questions, please contact us 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 _____

A. Questions to help determine whether an employee has a disability.

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

If yes, what is the impairment? (If additional space is needed, please use the back of this form). _____

Is the impairment long-term or permanent? Yes No

If not permanent, how long will the impairment likely last? _____

Answer the following questions based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if mitigating measures are not 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.

Does the impairment substantially limit one or more major life activities? Yes No

Note: Does not need to significantly or severely restrict to meet this standard.

If yes, what major life activity(s) is/are affected? 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"/> Reaching |
| <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"/> Sleeping |
| <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Thinking | <input type="checkbox"/> Toileting | <input type="checkbox"/> Reproduction |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Other (describe) _____ | | | | |

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

Note: Does not need to significantly or severely restrict to meet this standard.

If yes, what bodily function(s) is/are affected?

Form Continues on Next Page

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Immune | <input type="checkbox"/> Hemic | <input type="checkbox"/> Circulatory | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Digestive | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Brain | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Reproductive | <input type="checkbox"/> Bowel | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Special Sense | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Reproduction | <input type="checkbox"/> Special Sense Organs and Skin | |
| <input type="checkbox"/> Other (describe) _____ | | | |
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B. Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the required accommodation is needed because of the disability. Please see the job description attached.

What limitation(s) is interfering with job performance? _____

How does the employee's limitation(s) interfere with his/her ability to perform the job functions and to what extent? _____

What job function(s) is the employee having trouble performing because of the limitations? _____

*****Form Continues on Next Page*****

C. Questions to help determine effective accommodation options.

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations.

Do you have any suggestions regarding possible accommodations to improve job performance?

Yes No

If yes, what are they? _____

How would your suggestions improve the employee's job performance?

D. Comments.

Practitioner's Signature _____ **Date Completed** _____

Practitioner's Printed Name _____