ADA Job Accommodation Request and Medical Inquiry Form

American's with Disabilities Act (ADA) and American's with Disabilities Act Amendments Act (ADAAA)

The purpose of this form is to assist the University in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform the essential functions of their job safely and effectively. ***This form is filed separately from the employee's personnel file and is treated confidentially****.*

Section I to be completed by employee:

Employee Name: _____
Job Title: _____ Dept./School: _____
Work Address: _____ Work Telephone Number: _____
Home Telephone Number: _____ Email: _____
Immediate Supervisor: _____

1) Days/Hours of Work (ex. M-F, 8am – 5pm):
_____

2) Briefly describe the work you do (Desk job/physical job; inside/outside; main job duties; any physical requirements of the job, ex., lifting, pushing, pulling, etc.):

3) Accommodation Being Requested (*use back to continue if necessary)*

4) Reason for Accommodation (*identify condition and functional limitation(s) for which you seek an accommodation*):

Condition:

Functional limitation(s):

I understand that submitting this form is an initial step only and Northern Kentucky University (NKU) must confirm the existence and extent of the disability and how it may relate to the duties and responsibilities of the position involved. I also understand that this information is necessary so that NKU can respond to this request, and that this form and any attachments I have provided may be shared with the health care providers I have identified, as well as the other health care providers with whom NKU may consult in evaluating this request.

I further acknowledge that consideration of this request may require disclosure of information about my impairment to supervisors and others at NKU who may have a need to know enough about the impairment to participate effectively in discussions about possible accommodations, and/or in implementing accommodations. I agree to provide any other information needed in order to respond to this request.

I give Northern Kentucky University Office of Human Resources, Employee Relations Department permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act of 1990, as amended (ADA). I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements.

Signature: _____ Date: _____

Section II: To be completed by the medical care provider *directly involved with the care for the impairment identified in the ADA Job Accommodation Request and Medical Inquiry Form.*

Instructions to the Physician

A request for a reasonable accommodation has been made by our employee, _____.
In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise and treatment of this individual. Please answer the questions on this form to help determine the need for reasonable accommodation(s).

Background

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities, or has a record of such an impairment and the impairment does not have an actual or expected duration less than or equal to six months.

The Americans with Disabilities Act (ADA) provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communication, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

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.

Questions to assist in determining whether an employee has a disability: *The following questions may help determine whether an employee has a disability:*

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

2) What is the impairment?

_____

_____

3) How long will the impairment likely last?

- ☐ > 6 months
- ☐ 6 months – 1 year
- ☐ 1 year – 3 years
- ☐ 3 years – Indefinite

4) Does the impairment substantially limit a major life activity as defined by the ADA? Yes No

If yes, what major life activity, as defined by the ADA, is substantially limited?

_____

_____

Questions to assist in determining whether an accommodation is needed: *The following questions may help determine whether the requested accommodation is needed because of the disability:*

6) What limitation(s) is/are interfering with the ability to perform the essential functions of the job?

_____

_____

_____

7) What job functions(s) is/are the employee having trouble performing because of the impairment?

_____

_____

Questions to assist in determining effective accommodation options: *The following questions may help determine effective accommodations:*

8) Please provide suggestions regarding possible accommodations needed for the employee to perform the essential functions of their job?

_____

_____

_____

9) If implemented, how would these accommodations allow the employee to perform the essential functions of their job?

_____

_____

_____

The ADA Job Accommodation Request and Medical Inquiry Form authorization shall remain valid for 180 days following receipt by the NKU Office of Human Resources. A photocopy of the authorization will be accepted in lieu of the original.

Medical Care Provider Signature: _____

Date: _____

Medical Care Provider Name: _____

Medical Care Provider Contact Info: _____

_____

Return completed form to:

HR Department, LAC 708
100 Nunn Drive
Highland Heights, KY 41099
859-572-6998 (fax)
859-572-5200 (phone)