UT Southwestern Medical Center

Formal Request For Accommodation Due to Disability

All information regarding an individual's medical condition and the reasonable accommodation request is confidential and only disclosed to persons on a need to know basis. Any and all documents related to this request are kept confidential and will be maintained and used in accordance with applicable state and federal law.

Instructions: Individuals who are employed at the UT Southwestern Medical Center and are requesting a reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act, relevant state law, and accompanying state and federal regulations, are encouraged to complete this form in its entirety.

In order to explore possible coverage and reasonable accommodations, information is required regarding your medical condition, essential job functions, applicable functional limitations and your requested accommodation(s). It is often necessary for staff of the Office of Institutional Equity and Access to discuss your medical condition and the documentation you submit to our office with providers such as licensed physicians, psychologists, or other qualified professionals. If you need help in completing this form, someone else may complete it on your behalf, or you may contact the Office of Institutional Equity and Access for assistance. To reach our office, please call 214.648.4343.

Upon completion, please forward this form, along with the **Authorization to Release Medical Information Form**, to the Office of Institutional Equity and Access. Make sure you sign both forms.

Contact Information for ADA purposes:
Office of Institutional Equity and Access
UT Southwestern Medical Center
6363 Forest Park Rd., BL11.306
Dallas, TX, 75235
Telephone - 214.648.4343
Facsimile - 214.648.4348

Email –
EqualOpportunity@utsouthwestern.edu

☐ Faculty ☐ Employee/Staff ☐ Other (specify) _____

Name: _____
First Middle Last

Person #: _____ Job Title: _____

Department: _____

Work Telephone Number: _____

Personal Email: _____

Home Address: _____
City State ZIP Code

Home Telephone Number: _____

Preferred method of contact: ☐ Home Phone ☐ Email ☐ Work Phone

How long have you worked in current position? _____

Supervisor's Name: _____
First Last

Medical Information

1. Please Identify the medical condition(s) for which you are requesting an accommodation.

A. Is this request related to surgery? (If no, please leave "b" and "c" blank) ☐Yes ☐ No

B. If yes, what is the underlying condition and or impairment that necessitated surgery?

_____

C. Please provide the date of surgery. _____

2. Please provide the name and contact information for the health care professional who diagnosed the medical condition(s) listed above. Please include the date of diagnosis.

3. What is the expected duration of this disability?

Job and Accommodation Information

4. Are you presently able to perform your essential job function with or without an accommodation? If no, when do you expect to return to work with or without an accommodation?

5. Please explain how your medical condition(s) listed above affect(s) your ability to perform the essential functions of your position. If you are a new employee, state the anticipated difficulties you foresee in completing your job duties. Be specific regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

6. Please provide your recommendations for a reasonable accommodation(s) and any information you may have about any associated costs (attach supporting documentation).

7. How long will these accommodations be necessary?

8. Please describe any assistive technology or other devices that you are currently using that enable you to perform your job duties.

9. Please list any alternatives to your above listed recommendation(s) for a reasonable accommodation that you would like UTSW to consider.

Acknowledgment

I understand that it will be my responsibility to complete a Medical Release Form and provide it to the Office of Institutional Equity and Access for my request to be evaluated. I further understand that the Office of Institutional Equity and Access will evaluate and respond to me based upon the information that I provide.

_____ _____

Signature Date

☐ Please check here if additional information is attached to this request.

UT Southwestern Medical Center

Authorization to Release Medical Information

Please Note:
Your request cannot be processed until you have completed and submitted all required forms.

Instructions to Employee: Please complete the health care provider information section and sign the authorization below. If you have more than one provider, you must complete a separate form for each of your health care providers.

In addition, please print your first and last name in the UTSW Employee's Name line at the top of page 4. This helps your Health Care Provider identify who the Medical Certification is for should you submit these forms to our office separately.

Upon completion, please forward this form, along with the **Formal Request for Accommodation Due to Disability**, to the Office of Institutional Equity and Access. Make sure you sign both forms.

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This Form to Be Completed by Employee

Employee Name: _____
First Middle Last

Date of Birth: _____/_____/_____ Phone: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I have requested an accommodation from The University of Texas Southwestern Medical Center (UT Southwestern) under The Americans with Disabilities Act (ADA) of 1990, as amended. I hereby authorize my health care provider _____ to provide all information necessary for the evaluation of my request and to communicate directly with the UT Southwestern Office of Institutional Equity and Access in connection with the evaluation of my request.

This authorization is valid from the date of my signature below and unless otherwise revoked shall expire upon my separation from employment. I understand I may revoke this authorization at any time, except to the extent UT Southwestern has relied upon this authorization, by sending a written statement of revocation that specifically refers to this authorization to the Office of Institutional Equity and Access at the address provided on the left of this page.

I understand this authorization is voluntary and I may refuse to sign. UT Southwestern may not condition my health care services on the completion of this authorization. By signing this authorization I represent to UT Southwestern, its agents and employees that I am of sound mind and that I have read this authorization and fully understand the terms contained herein (including the Confidentiality Notice below). I understand that UT Southwestern will provide me with a copy of this signed authorization form.

Signature: _____ Date:_____

Printed Name: _____

CONFIDENTIALITY NOTICE: Medical-related information will be maintained separately from other personnel records in a confidential manner in accordance with state and federal laws. Supervisors and managers may be provided with information necessary to make determinations in connection with a request for an accommodation. First aid and safety personnel may be provided with information necessary to respond in case of an emergency.

UT Southwestern Medical Center

Health Care Provider Certification

NOTE: the information sought on this form pertains only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act.

Dear Health Care Provider:
Our employee, has submitted a request to The University of Texas Southwestern Medical Center (UT Southwestern) for a reasonable accommodation under the Americans with Disabilities Act (ADA), as amended. To assist us in assessing the employee's request for a reasonable accommodation, we ask that you provide answers to the following questions based on your medical expertise.

Upon completion, please forward this form, to the Office of Institutional Equity and Access.

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UT Southwestern Medical Center
6363 Forest Park Rd., BL11.306
Dallas, TX, 75235
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EqualOpportunity@utsouthwestern.edu

Revised 11/18

This Form to Be Completed by the Health Care Provider.

INSTRUCTIONS: Enclosed please find a signed authorization permitting you to disclose this information to UT Southwestern Medical Center. Please complete and sign this certification.

UTSW Employee's Name: _____

Health Care Provider's Name: _____

Specialization/Type of Practice:_____

Office Address: _____
City State ZIP Code

Fax No.: _____ Phone No.: _____

Email address: _____

Questions to help determine whether an employee has a qualifying disability.
A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

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

2. What is the impairment (diagnosis)? _____

3. Is this a request related to the employee's need to have surgery? (If no, please skip to question 4). ☐ Yes ☐ No
   A. If yes, what is the underlying condition and/or impairment that necessitated surgery?
   _____
   B. When is the date of surgery? _____

4. Is the impairment permanent? ☐ Yes ☐ No

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

6. Is this a condition which:
   A. requires periodic visits for treatment by a health care provider? ☐ Yes ☐ No
   B. continues over an extended period of time? ☐ Yes ☐ No
   C. may cause episodic rather than a continuing period of incapacity? ☐ Yes ☐ No

7. Is the patient taking medications or treatments that would be expected to affect job performance, or would pose a direct threat or safety risk? ☐ Yes ☐ No
   If yes, please explain.

8. Does the impairment affect a major life activity? (e.g., caring for self, interacting with others, performing manual tasks, breathing, toileting, walking, standing, reaching, thinking, sitting, hearing, seeing, speaking, learning, reproduction, lifting, sleeping, concentrating, working, major bodily functions, etc.)? ☐ Yes ☐ No
   If YES, please specifically identify the major life activity/activities that is/are affected:

In the section below: please indicate the limitations that the underlying impairment is causing the employee.
This would not include symptoms of a normal pregnancy. Also, as applicable, please describe the employee's condition pre-surgery.

Indicate What Bodily Functions are Affected

Immune System
☐ Mild ☐ Moderate ☐ Severe

Bowel
☐ Mild ☐ Moderate ☐ Severe

Brain
☐ Mild ☐ Moderate ☐ Severe

Endocrine
☐ Mild ☐ Moderate ☐ Severe

Normal Cell Growth
☐ Mild ☐ Moderate ☐ Severe

Bladder
☐ Mild ☐ Moderate ☐ Severe

Respiratory
☐ Mild ☐ Moderate ☐ Severe

Reproductive Functions
☐ Mild ☐ Moderate ☐ Severe

Digestive
☐ Mild ☐ Moderate ☐ Severe

Neurological
☐ Mild ☐ Moderate ☐ Severe

Circulatory
☐ Mild ☐ Moderate ☐ Severe

Other, Please explain:
☐ Mild ☐ Moderate ☐ Severe

Indicate Level of Limitation in Physical Activity

Sitting
☐ Mild ☐ Moderate ☐ Severe

Standing
☐ Mild ☐ Moderate ☐ Severe

Walking
☐ Mild ☐ Moderate ☐ Severe

Bending Over
☐ Mild ☐ Moderate ☐ Severe

Climbing
☐ Mild ☐ Moderate ☐ Severe

Kneeling
☐ Mild ☐ Moderate ☐ Severe

Pushing & Pulling
☐ Mild ☐ Moderate ☐ Severe

Crouching/Stooping
☐ Mild ☐ Moderate ☐ Severe

Breathing
☐ Mild ☐ Moderate ☐ Severe

Caring for Self
☐ Mild ☐ Moderate ☐ Severe

Interacting with others
☐ Mild ☐ Moderate ☐ Severe

Learning
☐ Mild ☐ Moderate ☐ Severe

Seeing
☐ Mild ☐ Moderate ☐ Severe

Lifting or Carrying - 10 lbs. or less
☐ Mild ☐ Moderate ☐ Severe

Lifting or Carrying - 11 to 25 lbs.
☐ Mild ☐ Moderate ☐ Severe

Lifting or Carrying - 26 to 50 lbs.
☐ Mild ☐ Moderate ☐ Severe

Lifting or Carrying - 51 to 75 lbs.
☐ Mild ☐ Moderate ☐ Severe

Lifting or Carrying - 76 to 100 lbs.
☐ Mild ☐ Moderate ☐ Severe

Lifting or Carrying - Over 100 lbs.
☐ Mild ☐ Moderate ☐ Severe

Repetitive Use of Hands - Right Hand
☐ Mild ☐ Moderate ☐ Severe

Repetitive Use of Hands - Left Hand
☐ Mild ☐ Moderate ☐ Severe

Repetitive Use of Hands - Both Hands
☐ Mild ☐ Moderate ☐ Severe

Grasping - Right Hand
☐ Mild ☐ Moderate ☐ Severe

Grasping - Left Hand
☐ Mild ☐ Moderate ☐ Severe

Grasping - Both Hands
☐ Mild ☐ Moderate ☐ Severe

Sleeping
☐ Mild ☐ Moderate ☐ Severe

Indicate Level of Mental, Emotional, and Sensory Limitations

Manage Multiple Priorities
☐ Mild ☐ Moderate ☐ Severe

Intense Customer Interaction
☐ Mild ☐ Moderate ☐ Severe

Multiple Stimuli
☐ Mild ☐ Moderate ☐ Severe

Frequent Change
☐ Mild ☐ Moderate ☐ Severe

Short-term Memory
☐ Mild ☐ Moderate ☐ Severe

Long-term Memory
☐ Mild ☐ Moderate ☐ Severe

Attention Span
☐ Mild ☐ Moderate ☐ Severe

Reasoning
☐ Mild ☐ Moderate ☐ Severe

Hearing
☐ Mild ☐ Moderate ☐ Severe

Reading
☐ Mild ☐ Moderate ☐ Severe

Analyzing
☐ Mild ☐ Moderate ☐ Severe

Verbal Communication
☐ Mild ☐ Moderate ☐ Severe

Written Communication
☐ Mild ☐ Moderate ☐ Severe

Vision
☐ Mild ☐ Moderate ☐ Severe

Please refer to the employee's job functions when answering these questions.

Questions to help determine whether an accommodation is needed.

1. What limitation(s) in major life activities is/are interfering with this employee's job performance?

2. What essential job function(s) is the employee having trouble performing because of the limitation(s)?

3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the essential functions of their job?

Questions to help determine effective accommodation options.

4. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

5. How long will these accommodations be needed?

6. If there is presently no accommodation that will allow the employee to perform his/her job duties, when do you expect the employee to be able to return to work and perform his/her job duties with or without an accommodation?

_____ _____
Health Care Provider's Signature Date

☐ Please check here if additional information is attached to this request.