UNIVERSITY OF CENTRAL FLORIDA

Office of Institutional Equity

Reasonable Accommodation Request Form

Requestor Information

Employee ID: _____ Request Date: _____

Name: _____

Last *First* *M.I.*

UCF Affiliation: _____

☐ Faculty ☐ Staff ☐ Applicant ☐ Other _____

Primary Telephone: _____ Alternate Telephone: _____

Email: _____ Activity/Job Title: _____

College/Division: _____ Department: _____

Coordinator/Supervisor: _____

Campus Location/Address: _____

The Genetic Information Nondiscrimination Act of 2009 (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 individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Identify the physical and/or non-physical impairment(s) for which you are requesting accommodation and the expected duration of the impairment(s). Include the date of diagnosis.

2. Explain how the impairment(s) listed above affect(s) your ability to perform the essential functions of your position or to enjoy equal benefits/privileges of employment. If you are a new employee, state anticipated difficulties you foresee in completing your job duties, or enjoying equal benefits/privileges of employment. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

3. List the accommodation(s) you are requesting in order to perform your essential job functions, or to enjoy equal benefits/privileges of employment. *(Non-faculty employees: please attach your position description to the Provider Certification of Disability Form.)*

If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? ☐ Yes ☐ No

If yes, please explain: _____

Is your accommodation time sensitive? ☐ Yes ☐ No

If yes, please explain: _____

4. Please provide any additional information that may be helpful in processing your request.

5. Medical verification of the impairment(s) (check the appropriate box(es)):

☐ I have enclosed the applicable medical documents with this request.

☐ I have NOT enclosed the applicable medical documents with this request. Explain below.

☐ ** I believe that I have already provided sufficient medical information to:

_____ , _____ at _____.
(Name) (UCF Job Title) (Contact Information)

☐ The disability and need for a reasonable accommodation is obvious and no medical documentation is needed. Explain below.

** For example, if you have requested FMLA leave for the same impairment(s), the Certification of Health Care Provider form for employees of serious health conditions may suffice.

Release of Information: I hereby certify that all statements made above are true and accurate to the best of my knowledge and belief. I hereby authorize the release of the above information to the University of Central Florida for the purpose of determining if I am a qualified individual with a disability and the appropriateness of the requested reasonable accommodation(s). I understand that it will be my responsibility to complete a Medical Release Statement and to furnish a Provider Certification of Disability, if required, to the UCF OIE for my request to be evaluated. I further authorize the University of Central Florida to seek clarification of this document and the Provider Certification of Disability, if necessary, by contacting my physician(s) or healthcare provider(s).

_____ _____

Requestor's Signature *Date*

**** Please return this completed form to:**
Office of Institutional Equity
University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81) Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu

UNIVERSITY OF CENTRAL FLORIDA

Office of Institutional Equity

Medical Information Request Form – Healthcare Provider

Medical Release
(Completed by the Requestor)

Name: _____
Last *First* *M.I.*

Employee ID: _____ Date of Birth: _____

UCF Affiliation: _____

☐ Faculty ☐ Staff ☐ Applicant ☐ Other _____

Primary Telephone: _____ Alternate Telephone: _____

Email: _____ Activity/Job Title: _____

Name of Healthcare Provider: _____

Healthcare Provider's Phone: _____

I, _____ (print name), hereby authorize the above-named healthcare provider to complete this form and disclose to the University of Central Florida and its authorized representatives the following information related to my healthcare: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my work, recommendations, history, reports and correspondence.

I understand that it may be necessary for the University representatives to share this information for purposes related to accommodation of a disability. I authorize the University to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process.

This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named healthcare provider will not condition treatment or payment based on receipt of this signed authorization.

_____ _____
Requestor's Signature *Date*

DO NOT RETURN THIS FORM TO YOUR DEPARTMENT

**** Please return all completed health care provider portions of this form to: Office of Institutional Equity, University of Central Florida**
12701 Scholarship Drive, Suite 101 (Building 81)
Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu

Medical Certification
(Completed by Healthcare Provider)

To the Healthcare Provider:

Your assistance is appreciated in providing information to assist in determining reasonable accommodation for the above named individual, who has identified himself/herself as your patient. The information you provide is critical to our ability to determine the appropriate services and/or accommodations, if any, for this person. Please be thorough in your evaluation as you complete the attached sections as it will help us assist your patient. **Your timely completion of this form is essential to our ability to respond to your patient's accommodation request. In addition, please do not collect and provide genetic information, including family medical history.**

Please complete all sections checked below. If you fax the completed form, please send the original hard copy by mail to the address designated at the bottom of page one.

☒ **I. Evaluation Summary**	☒ **V. Other Restrictions & Effects of Medication**
☒ **II. Ability to Work Summary**	☒ **VI. Recommended Accommodations**
☒ **III. Physical Capacities Evaluation** *(if applicable)*	☒ **VII. Signature of Health Care Provider**
☒ **IV. Cognitive/Psychological Capacities Evaluation** *(if applicable)*	☐ **Appendix A: Physical Capacities Evaluation Chart** ☐ **Appendix B: Cognitive Capacities Evaluation Chart**

I. Evaluation Summary

** Please identify the requestor's physical or non-physical impairment(s):

Please describe the effects or limitations and expected duration (e.g., long-term, permanent, recent, temporary):

Please describe the effects or limitations of the impairment(s) with relation to the requestor's activities, if any:

Is this condition the result of an on-the-job illness or injury? ☐ Yes ☐ No

II. Ability to Work Summary

Please check appropriate box:

My assessment is based on (*select one*): ☐ Written Job/Activity Analysis ☐ Written Job/Activity Description ☐ Job/Activity as described by Requestor

A. Choose **only one** of the following:

☐ The requestor/patient **CAN now** perform **all** the duties of the CURRENT job/activity without restriction: {IF CHECKED, STOP HERE, SIGN AND RETURN FORM}

☐ The requestor/patient **CAN now** perform all the duties of the CURRENT job/activity **with proposed accommodation(s)**. (Complete Section B)

☐ The requestor/patient **CAN** return to this job/activity after a medically necessary leave. (Complete Section C), or

☐ The requestor/patient **CANNOT, and will not be able to perform the essential duties of the current position even after a leave of 6 months**, and **CANNOT** work at least 50% time in **another job**: {IF CHECKED, STOP HERE, SIGN AND RETURN THE FORM}

☐ The requestor/patient **will not be able to perform the essential duties of the current position within the next 6 months**, but **CAN now** work at least 50% time in another job with the following limitations: _____ _____. State maximum percent time_____.

B. **I recommend a** ☐ **Temporary or** ☐ **Permanent** modification of the Requestor's job/activity that I have determined to be medically necessary (*e.g. work schedule, lifting, graduated return to work, etc.*)

Duration of proposed modification: from: (mm/dd/yy)_____to: (mm/dd/yy)_____.

C. I recommend a medical leave of absence from: (mm/dd/yy)_____to: (mm/dd/yy)_____.

Employee/patient will be able to return to work on: (mm/dd/yy)_____.

III. Physical Capacities Evaluation

Patient Name Last First MI

Please describe the effect or limitations of any physical impairment(s) which substantially limit(s) one or more major life activities and explain how such impairment(s) interfere(s) with the requestor/patient's ability to perform essential job functions or enjoy equal benefits and privileges of employment if not accommodated (*for non-faculty requestor/patients please review the attached information concerning the job duties*):

How often is the patient receiving treatment from you and/or another healthcare provider for this condition?

You may, but are not required, to use the evaluation chart in Appendix A for assistance with your evaluation.

IV. Cognitive/Non-Physical Capacities Evaluation

Patient Name Last First MI

Please describe the effect or limitations of any non-physical impairment(s) which substantially limit(s) one or more major life activities and explain how such impairment(s) interfere(s) with the requestor/patient's ability to perform essential job functions or enjoy equal benefits and privileges of employment if not accommodated (*for non-faculty requestor/patients please review the attached information concerning the job duties*):

How often is the patient receiving treatment from you and/or another healthcare provider for this condition?

You may, but are not required, to use the evaluation chart in Appendix B for assistance with your evaluation.

V. Other Restrictions & Effects of Medication

If there are other restrictions you have not described above, please describe here:

What is the anticipated duration of these restrictions?

Are these restrictions medically necessary? ☐ Yes ☐ No

Is patient currently prescribed medication that would impair ability to operate machinery, be punctual, or maintain regular attendance? ☐ Yes ☐ No

If Yes, please explain, including the expected duration that employee will be prescribed this (or similar) medication:

VI. Recommended Accommodations

Please offer any suggested accommodations **and** explain how each accommodation would enable the requestor/patient to perform essential job functions or enjoy equal benefits/privileges of employment:

If the requested accommodation is time taken off from work, how much is recommended?

Are there any activities or situations that should be avoided or that would present a significant risk of serious injury or death for the requestor?

VII. Signature of Healthcare Provider			
Thank you for your assistance in providing this information so that we may assess the requestor/patient's request. If you have any questions about this form, please contact the Office of Institutional Equity at (407) 823-1336.			
Healthcare Provider Name (please print or type)			
Provider's Degree/Specialty: Please indicate any board certifications		License No.	
Address (Street)	City	State	ZIP
_____ Healthcare Provider's Signature Date		Phone No.	Fax No.

**** Please return all completed healthcare provider portions of this form**
to: Office of Institutional Equity, University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81)
Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu

APPENDIX A

IMPORTANT: Please only complete the following items based on your clinical evaluation of the patient and other testing results. Any items that you do not believe you can answer should be marked "N/A".

A. In one shift, patient can (mark or check (✓) full capacity for each activity).

	Never	Rarely Once a week or less	Occasionally 0-2.5 hrs.	Frequently 2.5-5.5 hrs.	Continuously 5.5+ hrs.
Sit					
Stand (in place)					
Walk					

B. Patient can lift

	Never	Rarely Once a week or less	Occasionally 0-2.5 hrs.	Frequently 2.5-5.5 hrs.	Continuously 5.5+ hrs.
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

C. Patient can carry

	Never	Rarely Once a week or less	Occasionally 0-2.5 hrs.	Frequently 2.5-5.5 hrs.	Continuously 5.5+ hrs.
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

D. Patient can push/pull

	Never	Rarely Once a week or less	Occasionally 0-2.5 hrs.	Frequently 2.5-5.5 hrs.	Continuously 5.5+ hrs.
0 to 10 lbs.					
11 to 25 lbs.					
26 to 50 lbs.					
51 to 100 lbs.					

E. Patient is able to

	Never	Rarely Once a week or less	Occasionally 0-2.5 hrs.	Frequently 2.5-5.5 hrs.	Continuously 5.5+ hrs.
Bend					
Squat					
Kneel					
Climb					
Reach Out					
Reach Above Shoulder Level					
Turn/twist (upper body)					

F. Patient is able to

	Never	Rarely Once a week or less	Occasionally 0-2.5 hrs.	Frequently 2.5-5.5 hrs.	Continuously 5.5+ hrs.
Operate Heavy Machinery					
Drive a stick shift vehicle					
Work with or near moving machinery					

G. Patient can use hands for repetitive action such as:

☐ Not applicable to this patient

	Left		Right		TOTAL HOURS AT ONE TIME		TOTAL HOURS DURING ONE SHIFT	
	Yes	No	Yes	No	Left	Right	Left	Right
Simple Grasping								
Pushing & Pulling								
Fine Manipulating								
Keyboarding or Typing								

Clarify or add any additional information here:

APPENDIX B

IMPORTANT: Healthcare Provider – Please identify functional limitations of diagnosis(es):	
Patient has the ability to meet the cognitive demands of the job as described in the cognitive job analysis or job description. (*select one*) ☐ Cognitive Job Analysis ☐ Job Description ☐ Job as described by employee	☐ Yes ☐ No
Patient has the ability to meet the psychological demands of the job as described in the cognitive job analysis or job description. (*select one*) ☐ Cognitive Job Analysis ☐ Job Description ☐ Job as described by employee	☐ Yes ☐ No
Patient has the ability to multitask without loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources.	☐ Yes ☐ No
Patient has ability to work and sustain attention with distractions and/or interruptions.	☐ Yes ☐ No
Patient is able to interact appropriately with a variety of individuals including customers/clients.	☐ Yes ☐ No
Patient is able to deal with people under adverse circumstances.	☐ Yes ☐ No
Patient has the ability to work as an integral part of a team. Includes ability to maintain workplace relationships.	☐ Yes ☐ No
Patient is able to maintain regular attendance and be punctual.	☐ Yes ☐ No
Patient is able to understand, remember and follow simple verbal and written instructions.	☐ Yes ☐ No
Patient is able to understand, remember and follow detailed verbal and written instructions.	☐ Yes ☐ No
Patient is able to complete assigned tasks with minimal or no supervision.	☐ Yes ☐ No
Patient is able to exercise independent judgment and make decisions.	☐ Yes ☐ No
Patient is able to perform under stress and/or in emergencies.	☐ Yes ☐ No
Patient is able to perform in situations requiring speed, deadlines, or productivity quotas.	☐ Yes ☐ No
Clarify or add any additional information here:	