ADAA MEDICAL ACCOMMODATION & CERTIFICATION REQUEST FORM

Faculty and Staff should complete this form if they would like to request a work accommodation. Once a request for an accommodation is received, Human Resources will engage in an interactive process to determine the individual needs and identify appropriate and reasonable accommodation(s). Human Resources will inform the employee or applicant in writing of the decision. Please return the completed form to the Human Resources Department, Email: AskHR@wfu.edu or Fax: (336)758-6217.

An annual recertification of the accommodation request will be required.

SECTION I: *To be completed by the employee.*

Name: _____ Scheduled Return to Campus Date: _____

WFU ID#: _____ Department: _____

Email: _____ Job Title: _____

Phone Number: _____ Dean or Supervisor: _____

Briefly describe the nature of your work (student-facing, desk work, physical work, etc.):_____

_____

_____

Please specify the accommodation that would meet your need, based on your current medical condition:

_____

_____

_____

Employee Signature: _____Request Date:_____

SECTION II: *To be completed by the physician or health care provider.*

1. Does the patient have a physical or mental disability?

❑ Yes ❑ No If Yes, what is the impairment?_____

2. How does the patient's disability impair or limit their ability to perform assigned job duties ?

_____

_____

3. Is this a permanent or temporary disability?

❑ Yes ❑ No If No, what is the expected duration of the disability?_____

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4. What major life activity(s) are affected for the above-named patient?

- ❑ Bending
- ❑ Breathing
- ❑ Concentrating
- ❑ Thinking
- ❑ Hearing
- ❑ Learning
- ❑ Lifting
- ❑ Walking
- ❑ Reaching
- ❑ Reading
- ❑ Seeing
- ❑ Sitting
- ❑ Sleeping
- ❑ Speaking
- ❑ Standing
- ❑ Other:_____

5. What major bodily functions are affected for the above-named employees?

- ❑ Bladder
- ❑ Bowel
- ❑ Brain
- ❑ Cardiovascular
- ❑ Circulatory
- ❑ Digestive
- ❑ Endocrine
- ❑ Genitourinary
- ❑ Hemic
- ❑ Immune
- ❑ Lymphatic
- ❑ Musculoskeletal
- ❑ Neurological
- ❑ Normal Cell Growth
- ❑ Operation of an Organ
- ❑ Reproductive
- ❑ Respiratory
- ❑ Special Sense Organs & Skin
- ❑ Other:_____

5. Please describe the recommended accommodation(s) that could enable the staff member to perform their job duties.

_____

_____

_____

_____

_____

Provider Certification:

Provider Name (printed): _____ (signature): _____

Name & Location of Practice:_____

Date: _____Telephone: _____Fax: _____

TO BE COMPLETED BY HUMAN RESOURCES:

Approved Plan Includes: _____

_____

_____

Accommodation: Accepted Declined HR Rep.: _____ **Date:**_____