ADA Medical Accommodation & Certification Request Form

Wake Forest University (WFU) is committed to the fair and equal employment of individuals with disabilities. It is the policy of WFU to reasonably accommodate qualified individuals with disabilities when accommodation is necessary to allow an individual to compete for a job, perform the essential functions of a job, and/or enjoy equal benefits and privileges of employment, unless the accommodation would impose an undue hardship. Faculty and Staff who wish to request an accommodation should complete Sections I and II below. Once a request for an accommodation is received, Human Resources will engage in an interactive process to determine the individual needs and identify (an) appropriate and reasonable accommodation(s). Employees are responsible for providing a job description to the physician or health care provider. Faculty duties may be found in the Faculty Handbook (Chapter 3).

Please return the completed form within 15 calendar days of receiving it from WFU to the Human Resources Department, Email: AskHR@wfu.edu or Fax: (336)-758-6127.

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

Name: _____

WFU ID#: _____ Department: _____

Email: _____ Job Title: _____

Phone Number: _____ Dean or Supervisor: _____

Type of Accommodation Requested (Check One)

1. What type of accommodation are you requesting?

- ☐ Adjustments in the way the job is normally performed
- ☐ Adjustments to the work schedule
- ☐ Other (please specify): _____

_____

2. Please provide additional details regarding the type of accommodation you are requesting, using additional paper if needed. (Be as specific as possible):

_____

_____

Reason for Request

3. Describe the precise job-related limitations caused by the disability, using additional paper if needed:

_____

_____

4. How long do you expect to need this accommodation? _____

Employee Signature: _____Request Date:_____

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

Note to physician or healthcare provider: Please complete this form with current and accurate medical information relating to the individual named below. Before completing the form, please also review the GINA Compliance Notice below.

GINA Compliance Notice

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.

1. Please list any specific functional limitations resulting from the patient's impairment (including limitations resulting from medication and/or other treatment) impacting the employee's ability to perform his/her job duties (e.g., cannot bend, stand, lift, push, pull, walk, climb, etc.).

☐ A copy of the patient's job description has been attached to this form

_____

_____

_____

2. Given the above-referenced functional limitations, please list below the specific job duties you believe the patient is unable to perform due to his/her impairment. Please identify the underlying functional restriction(s) which prevents the individual from performing the job duty, and identify the expected duration of each outlined restriction. (Attach additional sheets if necessary.)

	Job Duty	**Underlying Functional Restriction(s) Impacting Job Duty**	**Duration of Restriction(s)**
i.			
ii.			
iii.			
iv.			

3. Are there any reasonable accommodations you would suggest that may enable the individual to overcome the functional limitations referenced above and thereby enable the individual to perform the essential duties of the position? If so, please specify the reasonable accommodation and explain the factual and medical reasons why you believe the suggested accommodation is likely to be effective in addressing the individual's functional limitations. (Attach additional sheets if necessary).

_____

_____

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Provider Certification

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

Name & Location of Practice: _____

Date: _____ Telephone: _____ Fax: _____

SECTION III: *To be completed by Human Resources.*

Request for Accommodation Approved: □ __Yes □ __No

Approved Plan Includes: _____

_____

_____

_____

HR Rep.: _____ Date: _____