TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO

REQUEST FOR MEDICAL INFORMATION FOR REASONABLE ACCOMMODATION

DATE: ______________________

TO: ____

(Physician or Medical Provider)

FROM: ____

(Employee Name) (Tech ID - R#)

SUBJECT: **REQUEST FOR MEDICAL INFORMATION NEEDED TO ASSIST IN PROVIDING A REASONABLE ACCOMMODATION:**

I have requested a reasonable accommodation from my employer, Texas Tech University Health Sciences Center El Paso, to assist in providing employment or participation in a program, activity, or service. The information requested below is confidential and will only be used to determine the specific equipment and/or services necessary to accommodate the identified limitations due to the verified disability. 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.

Under the Americans with Disabilities Act and the Americans with Disabilities Act Amendments Act, an ***individual with a disability*** is a person who:

- Has a physical or mental impairment that substantially limits one or more major life activities (major life activity may include, but is not limited to, walking, breathing, speaking, performing a manual task, seeing, hearing, learning, caring for oneself, sitting, standing, lifting, or reading);
- Has a record of such an impairment; or
- Is regarded as having such impairment.

Please take the above definition into consideration and answer the following questions with respect to the Employee's request for reasonable accommodation:

1. Does the individual have an impairment that limits a major life activity? ___**YES** ___**NO**

   If yes, please see the second page of this form to describe the limitation.

2. Is the disability permanent? ___**YES** ___**NO** Length of anticipated duration ________________________________

3. From the enclosed job description, specify the job duty that the employee cannot perform ______________________________

   ____

4. How does the limitation(s), impair the ability of the Employee to perform the job duty described above?

   ____

   ____

   ____

____(______)________________________

Physician's Signature **Date** **Phone**

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Employee Name ______________________________ ***Tech ID (R#)*** ____________________

Instructions: Complete this form only if the answer to question #1 is yes.

Work Restrictions: Patient is restricted from or limited in performing the following functions (check activity and enter limitation, i.e.: 0 hours; 1-2 hours, 2-5 hours, 6-8 hours; or other notation);

☐ KEYBOARD USE/REPETITIVE USE OF HANDS	☐ GRASP/FINE FINGER MOTIONS
☐ SIT	☐ REPETITIVE USE OF FOOT CONTROLS
☐ STAND	☐ WALK
☐ SQUAT/KNEEL	☐ TWISTING (NECK/WAIST)
☐ BEND/STOOP	☐ CLIMB LADDERS/CLIMB STAIRS
☐ PUSH/PULL	☐ REACHING (Above and below shoulders)
☐ LIFT (Please specify lifting restriction)	☐ CARRY (Please specify carrying restriction)
☐ OTHER	

Describe any restrictions which may apply to the following:

☐ VISION
☐ HEARING
☐ MENTAL/EMOTIONAL
☐ OTHER (Sleeping, Speaking)