UNIVERSITY OF KENTUCKY ADA ACCOMMODATION REQUEST MEDICAL INQUIRY FORM

Name:_____ Birthdate:_____ UK Emp. ID:_____

******ENTIRE FORM MUST BE COMPLETED BY TREATING PROVIDER******

PROVIDERS: PLEASE ONLY ANSWER THE QUESTIONS ON THIS FORM IN RELATION TO THE DISABILITY THE EMPLOYEE IS SEEKING ACCOMMODATIONS FOR.

A. Questions to help determine whether an employee has a disability.

For reasonable accommodations under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee qualifies under the ADA as an individual with a disability:

Does the employee have a physical or mental impairment?	Yes ☐	No ☐
If *yes*, what is the impairment or medical condition?		

Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures (ex. medication, hearing aids, mobility devices, psychotherapy, etc.) were used. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population? ***Note:*** *Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.*	Yes ☐	No ☐ **OR** Describe the employee's limitations when the impairment is active.

If *yes*, what major life activity(s) is/are affected?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Other: (describe)
☐ Breathing	☐ Interacting With Others	☐ Reading	☐ Standing	
☐ Caring For Self	☐ Learning	☐ Seeing	☐ Thinking	
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working	

If *yes*, what major bodily functions is/are affected:

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

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B. Questions to help determine effective accommodation options. ***If continuous or intermittent leave is needed, please also fill out section C.***

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

What possible accommodations are suggested to assist the employee in their position?

How would the accommodations assist the employee with improving their job performance?

C. Questions to help determine why leave is needed.

An employee with a disability is entitled to an accommodation when the accommodation is needed because of the disability. If an employee is not eligible for or has exhausted FMLA, the employee may request intermittent or continuous leave under the ADA if the leave is needed due to a disability. The following questions may help determine whether the requested leave is needed because of the disability:

Why does the employee need leave? (e.g., obtaining medical treatment, recovering from a flare-up, etc.)

Please check the leave that is needed: Continuous Leave ☐ Intermittent Leave ☐

If continuous leave, how long is the leave needed and what are the dates the leave will be needed?

If intermittent leave, how much leave will the employee likely need? (e.g. half a day every other week, three flare-ups per month with a 2-day duration for each flare-up, three consecutive days each month)

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D. Other questions or comments.

Medical Professional Name (Print):_____

Medical Professional's Signature _____ Date: _____

Provider Practice/Specialty:_____

Provider Phone Number: _____

Provider Address: _____

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.

Please submit the completed form either by fax to 859-323-3739 (fax) or by email to ADAaccommodations@uky.edu.