University of Rochester

Reasonable Accommodation Request Form

Please complete and submit to your medical provider. Please include a copy of your job description.

In accordance with applicable law, the University of Rochester intends to provide reasonable accommodations to qualified individuals with disabilities, where such accommodations would enable employees to perform the essential functions of their jobs, unless doing so would pose an undue hardship. This commitment also extends to known physical or mental limitations of otherwise qualified individuals who seek employment at the University. The purpose of this form is to assist the University in determining whether, or to what extent, a reasonable accommodation can be provided to allow you to perform the essential functions of your job safely and effectively.

We will confirm your medical condition with your provider but ask that you answer the following questions to assist us in understanding the basis and nature of your request for an accommodation (attach additional sheets if necessary).

To be completed by employee or applicant seeking accommodation

Employee Name _____ Employee ID _____

Job Title _____ Department _____

Date _____

A. In what ways does your condition impact your ability to perform specific functions of your job (i.e., what specific functions or duties are you unable to perform without an accommodation due to your condition and why)?

B. Please describe as completely and specifically as possible the accommodation(s) you are requesting.

C. Please explain how you believe that the accommodation(s) requested above will allow you to continue to perform the essential functions of your position.

Note to Human Resources Business Partners and Liaisons: This form must be maintained and filed separately (under lock and key) from the employee's personnel file. The forms, and all medical information received as a result of the accommodation request process, will be treated confidentially in accordance with the law.

Employee Release of Medical Information

I authorize my physician or other health care provider, as defined by the *ADA, to release to the designated representative of the University of Rochester the information requested below, and any and all information which shall be required with respect to my diagnosis, functional limitations, and/or duration of disability. The medical condition for which I am requesting accommodation(s) is:

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, I ask that my physician not provide any genetic information in response to this request for medical information.

Employee Signature _____ Date _____

Request for Documentation to Certify Disability: To Be Completed by Physician or Health Care Provider

The above-mentioned individual is an employee of the University of Rochester. The employee has requested a workplace accommodation due to a medical condition potentially qualifying as a disability and has identified you as their treating physician. The employee believes that an accommodation is necessary to enable them to perform the essential functions of their job. Please answer the following questions, designed to assist the University in evaluating this request and return the form to your patient, who will in turn submit to their HR representative. The information you provide will be maintained confidentially, in accordance with the law.

1. Have you examined the above-mentioned employee in connection with the health condition(s) indicated on page 1 of this document? ○ Yes ○ No

   a. Is this person currently under your care for treatment of this health condition? ○ Yes ○ No

      If you answered "yes" to question 1a, please identify the specific physical or mental impairment*:

2. Is the impairment temporary or permanent? ○ Temporary ○ Permanent

   a. If the impairment is temporary, what is the expected duration of the impairment?

3. Attached is a copy of the employee's Job Description. In what specific way(s) and to what extent does the impairment affect the employee's ability to perform the functions of their job?

4. Is there a particular accommodation that would enable the employee to perform the essential requirements of their job that you recommend we consider implementing?

*The Americans with Disabilities Act, as amended, defines disability as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual[,]" having a record of such an impairment, or being regarded as having such an impairment. Physical impairment is defined as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin and endocrine" and mental impairment as "any mental or psychological disorder, such as an intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities." The NYS Human Rights Law defines disability as a physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques or a record of such an impairment or a condition regarded by others as such an impairment.

Provider Signature: _____ Date: _____

License # _____ State: _____

Name/Title: _____ Phone: _____

Address: _____

Submit the completed form electronically to:

Human Resources Business Partner (HRBP)

Name:

Email:

or to
RTW@ur.rochester.edu or Fax: (585) 235-6703