



## Accommodation Medical Request Form

The Disability Equity Office is requesting your assistance in facilitating a reasonable accommodation for a University of Michigan employee who has requested a workplace accommodation. This form is used to verify that they qualify as a person with a disability and helps the team determine how to best accommodate the employee, when possible. When an employee requests a workplace accommodation due to a disability or underlying medical condition, the University of Michigan, as the employer, may request this form to be completed and signed by the treating healthcare provider most familiar with the employee’s medical condition. If this form is not completed by the treating provider, the employee may submit appropriate medical documentation to support their request that provides 1) the employee’s medical diagnosis(es), 2) limitations imposed by the diagnosis(es), 3) recommended accommodation(s), and 4) the length of time for the recommended accommodations to be put into place.

### Section 1: Completed by Employee

Employee Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Summary of Primary Job Duties: \_\_\_\_\_

### Section 2: Completed by Health Care Provider

Please identify the diagnosis(es) for the above-named requestor:

\_\_\_\_\_

\_\_\_\_\_

Does the diagnosis(es) limit a major life activity (listed below) compared to most people in the general population?

Yes      No

What major life activity(ies) are affected:

- Bending    Working    Reading    Thinking    Interacting with others
- Breathing    Eating    Seeing    Walking    Performing manual tasks
- Lifting    Standing    Learning    Reaching    Concentrating
- Hearing    Speaking    Sitting    Caring for self
- Other \_\_\_\_\_



What major bodily function(s) is/are affected

- Bladder                      Digestive                      Lymphatic                      Reproductive
- Endocrine                      Brain                      Genitourinary                      Musculoskeletal
- Respiratory                      Hemic                      Bowel                      Neurological
- Immune                      Cardiovascular                      Circulatory                       Normal cell growth
- Special sense organs & skin                      Organ Transplant
- Other \_\_\_\_\_

Please add any additional information regarding the employee’s diagnosis:

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How does the employee’s limitation(s) interfere with their ability to perform the job function(s) or access a benefit of employment? \_\_\_\_\_

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**Recommended Workplace Accommodations:**

Please provide any recommendations for addressing the limitations experienced by the employee, or potential modifications or adjustments to the job duties or work environment of the employee.

- Addition of room dividers, partitions, or other soundproofing or visual barriers between workspaces to reduce noise or visual distractions.
- Gradual return to work plan. Explain timeline and limitations: \_\_\_\_\_

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- Provide leave. Specify frequency and length: \_\_\_\_\_

- Ergonomic equipment                      Breaks



- ASL Interpreter or CART services
  - Flexible start/end time
  - Reduce/Amplify/Change lighting
  - Modify work schedule
  - Modify job responsibilities
  - Provide product, equipment, or hardware (noise machine, recorder, larger monitors)
  - Provide private office space or private space enclosure
  - Other: \_\_\_\_\_
- Modify a policy
  - Assistive technologies (software, readers etc.)
  - Modify a facility for accessibility
  - Modify tests or training materials
  - Reduction/removal of distractions in area

**Timeline for restrictions, limitations, modifications, and adjustments:**

- Temporary. Provide the estimated end date for restrictions: \_\_\_\_\_
- Permanent/expected to last more than 6 (six) months.
- Unknown. Please explain: \_\_\_\_\_

**Section 3: Health Care Provider Information**

Provider Name and Area of Practice: \_\_\_\_\_

Name of Clinic/Medical Group: \_\_\_\_\_

Office Phone: \_\_\_\_\_ State Professional License No. \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Providers:** Please submit this form by email to: [DisabilityEquity@umich.edu](mailto:DisabilityEquity@umich.edu).

**Employees:** Please upload the completed document into your Accommodate case file at <https://ecrt-umich-accommodate.symplicity.com/>.

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.