UTHealth Houston

Accommodation Certification Form

Name:	

A. Questions to help determine whether a person has a qualifying disability under the ADA A person with a disability is a person with an impairment that substantially limits one or more major life activities or has a record of such impairment. The following questions may help determine whether this employee has a disability.	
Does the person have a physical or mental impairment that substantially limits one or more major life activities?	☐ Yes ☐ No
Does the impairment substantially limit a major life activity?	☐ Yes ☐ No

If **yes**, what major life activity is substantially limited? *(Check all that apply.)*

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Reaching ☐ Seeing ☐ Hearing

☐ Sleeping ☐ Speaking ☐ Breathing ☐ Working ☐ Thinking ☐ Learning

☐ Toileting ☐ Caring for Self ☐ Performing manual tasks ☐ Other: _____

☐ Operation of major bodily function (i.e. functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, reproduction)

Please specify: _____

Is the impairment permanent?	☐ Yes ☐ No

If ***not*** permanent, how long, to a reasonable medical certainty, will the impairment likely last? If the impairment is episodic and/or in remission, please specify **anticipated frequency and duration of incapacity or other limitation related to the individual's job** (*i.e.* is this something that will cause periodic flare-ups, and if so, how often and for how long, etc.).

Condition start date: __________ Expected length or ending date: __________

If episodic,

Frequency: __________ Times per: ☐ Week ☐ Month

Duration: __________ ☐ Hour(s) or ☐ Day(s) per episode

B. Questions to determine specific accommodation needs

Employee: What job-related limitations is the employee experiencing as a result of his/her medical condition?

C. Questions to help determine other effective accommodation options

Employee: Taking into consideration the nature, severity, and duration of the employee's impairment, the limitations imposed by the impairment, and the effect of the impairment on the employee's ability to perform the essential functions of the position, what alterations to the employee's work environment or situation, if any, may assist the employee in effectively performing the essential functions of the position *(e.g. alternative scheduling, use of accrued paid leave or additional paid leave, scheduled breaks, adaptive equipment, movement/effort restrictions, physical changes to the workplace or equipment, etc.)?* Additionally, what, if any, auxiliary aids/or services may assist the employee in effectively performing the essential functions of the position *(e.g. screen readers, sign language interpreters, assistive devices, etc.)*? Please include in your answer how long you anticipate these adjustments may be needed.

For leave:

Continuous leave: Beginning incapacity date: __________ Ending incapacity date: __________

Intermittent leave: If episodic,

Frequency: __________ Times per: ☐ Week ☐ Month

Duration: __________ ☐ Hour(s) or ☐ Day(s) per episode

If the health condition requires treatment or follow up appointments, please estimate the frequency and amount of time needed.

Frequency: __________ Times per: ☐ Week ☐ Month

Time needed for appointment: __________ ☐ Hour(s) or ☐ Day(s)

For suggested workplace adjustments:

Adjustment start date: __________ Expected length or ending date: __________

D. Comments

Note: 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.

Medical Provider Name (Print or Type):

Type of practice/medical specialty:

Address: **Telephone:**

Medical Provider Signature: **Date:**

Please return this form to
University Relations & Equal Opportunity
7000 Fannin St., Ste. 150; Houston, TX 77030
Email: CALL@uth.tmc.edu
Fax: 713-500-3131