**MEDICAL INFORMATION FOR ADA ACCOMMODATION REQUEST**

This form is to be completed by a UNH employee’s medical provider in support of the employee’s request for ADA reasonable accommodation. Please note this form can be completed digitally or may be printed out.

Date:

**Patient Information:**

|  |  |
| --- | --- |
|       |       |
| Patient Name | Patient DOB |
| Provider Name | Credentials |

|  |
| --- |
| Practice Name Date of Last Office Visit related to limitations |
| Practice Address |

Phone      ext             Fax

**Physical or Mental Impairment**

Does the employee have a physical or mental impairment that substantially limits one or more major life activities? Yes/No

Describe:

|  |
| --- |
|       |

**Limitations**

Limitations on major life activities: Answer the following questions based on what limitations the employee has when their condition is in an active state and what limitations the employee would have without regard to the ameliorative effects of any mitigating measures. Mitigating measures include, but are not limited to, things such as medication, medical supplies, equipment, hearing aids, mobility devices, assistive technology, auxiliary aids or services, prosthetics, etc. You should consider the ameliorative effects of ordinary eyeglasses or contact lenses, however, in determining whether an impairment sustainability limits a major life activity.

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

|  |  |  |
| --- | --- | --- |
| [ ] Bending | [ ] Learning | [ ] Sitting |
| [ ] Breathing | [ ] Lifting | [ ] Sleeping |
| [ ] Caring for Self | [ ] Performing Manual Tasks | [ ] Speaking |
| [ ] Concentrating | [ ] Reaching | [ ] Standing |
| [ ] Eating | [ ] Reading | [ ] Thinking |
| [ ] Hearing | [ ] Seeing | [ ] Walking |
| [ ] Interacting with Others |  | [ ] Working |

**Major Bodily Functions**

|  |  |  |
| --- | --- | --- |
| [ ] Bladder | [ ] Endocrine | [ ] Neurological |
| [ ] Bowel | [ ] Genitourinary | [ ] Normal Cell Growth |
| [ ] Brain | [ ] Hemic | [ ] Operation of an Organ |
| [ ] Cardiovascular | [ ] Immune | [ ] Reproductive |
| [ ] Circulatory | [ ] Lymphatic | [ ] Respiratory |
| [ ] Digestive | [ ] Musculoskeletal | [ ] Special Sense Organs |
| [ ] Other |  |  |

**Duration**

Please select the term that best describes the anticipated duration of the impairment. In the space following, describe the nature and severity of the impairment, including ancticipated duration if no permanent and frequency and duration of flares if chronic.

[ ] Temporary (describe):

|  |
| --- |
|  |

 [ ]  Chronic

 

|  |
| --- |
|  |

[ ]  Temporary with residual side effects:

|  |
| --- |
|  |

[ ]  Permanent:



|  |
| --- |
|  |

**Limitations**

What limitation(s) is interfering with the job performance or accessing a benefit of employment? What essential job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s) and how do they interfere with their ability to perform their job function(s) or access a benefit of employment?

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| --- |
|  |

**Accommodation Recommendations**

What accommodation(s) would you suggest may assist in performing the job function(s) affected by the impairment(s)? Why?

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| --- |
|  |

|  |  |
| --- | --- |
| Signature      | Date  |