Accommodation Request Medical Inquiry Form

RELEASE of Information:

I, _________________________________, hereby authorize the release of the following information to the University of North Carolina Wilmington for the purpose of determining my eligibility for workplace accommodations, as based on the federal guidelines for the definition of a disability and to obtain information related to my disability; any related limitations; and recommendations on necessary accommodations.

I have been given an opportunity to ask questions about this form and to have them answered to my satisfaction. I further understand that relevant information obtained may be shared with the supervisor(s) in my immediate work unit and other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work related responsibilities.

____________________________________
____________
Employee’s Signature Date

Request for Information from the Medical Provider
To be considered, this Healthcare Provider’s Statement must be based on clinical information and diagnosis that is current within six (6) months of the date of the accommodation request.

Name of Physician/Health Care Provider: ____________________________________________
Please Print

Name of Hospital/ Practice: __________________________________________________________

Address: _______________________________________________________________________

Telephone Number: __________________________ FAX Number ___________________

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 return completed form to: Human Resources Benefits Office
UNC-Wilmington
601 S. College Rd.
Wilmington, NC 28403
Attn: Patti Hale

Human Resources Ph: 910.962.3160
1. Does the employee have a physical or mental impairment?  
   Yes [ ]  No [ ]

2. If yes, what is the impairment?

   ____________________________________________________________________________________
   ____________________________________________________________________________________

3. Does the impairment substantially limit a major life activity as compared to most people in the general population?  
   Yes [ ]  No [ ]

   (Examples of major life activities include: bending, breathing caring for self, concentrating, eating, reaching, reading seeing sitting, sleeping, speaking standing, thinking, walking, working, and the operation of major bodily functions such as the bladder, bowel, brain, cardiovascular, circulatory, lymphatic, musculoskeletal, neurological, normal cell growth, operation of an organ, reproductive, respiratory, and special sense organs and skin)

   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.

4. What limitation(s) is interfering with job performance?

   ____________________________________________________________________________________
   ____________________________________________________________________________________

5. What job function(s) is the employee having trouble performing because of the limitation(s)?

   ____________________________________________________________________________________
   ____________________________________________________________________________________

6. How does the limitation interfere with the employee’s ability to perform the essential functions of his or her job?

   ____________________________________________________________________________________
   ____________________________________________________________________________________

7. Do you have any suggestions for possible accommodations that will enable the employee to perform the essential functions of the job? Please describe:

   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

   Attestation by Health Care Provider:

   ____________________________________________
   Medical Professional’s Signature

   ___________________________
   Date