AMERICANS WITH DISABILITIES ACT

EMPLOYEE ACCOMMODATION MEDICAL CERTIFICATION FORM

Section I: For Completion by the EMPLOYEE

Employee Name_____**UT EID**_____

Job Title_____**Department**_____

Employee Signature_____**Date**_____

I authorize my licensed healthcare provider to complete this form for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act, as amended.

Section II: For Completion by the HEALTHCARE PROVIDER

DEAR PHYSICIAN,

The above-referenced individual has identified you as the licensed health care provider who is treating the medical condition for which they are seeking reasonable accommodation. To assist us with this process, please complete this certification form. The individual should provide you with a copy of their job description. If no job description is available, please discuss the position with the individual to determine essential job functions. It is important to note that that the university is primarily a residential campus and an essential function of the faculty position is to provide in-person instruction. Additionally, some university employees have a position that requires them to provide consistent, daily, direct student support, as a result, their role may not lend itself to working remotely in any capacity.

Please answer the questions below to help determine disability and reasonable accommodation. Please write legibly; if clarification is needed, the University ADA Coordinators will contact you.

1. When did you start treating this patient for the medical condition/disability for which they are seeking a workplace accommodation?

2. What is the date of your most recent visit with this patient?

3. What is the individual's diagnosis? Please specify in the space provided:

4. Does the condition substantially limit a major life activity? If so, how?

5. Is the condition permanent?

- ☐ YES
- ☐ NO

If NOT permanent, how long will the impairment likely last?_____ # of weeks_____# of months.

6. Will the individual have episodic flare-ups that will prevent them from performing their job functions?

- ☐ YES
- ☐ NO

  - If YES, please estimate how often the flare-ups will prevent them from performing their job functions: Up to_____times per week, _____times per month, or_____times per year.

7. Check the following that apply and indicate the degree of limitation in a typical 8-hour workday:

- Please note that in a typical 8-hour workday: 65%= 5.2 hours and 33%= 2.64 hours.

Workday Activity	**Continuously limited,** individual is limited in this activity up to 65-100% of their workday.	**Frequently limited,** individual is limited in this activity up to 34-64% of their workday.	**Occasionally limited,** individual is limited in this activity up to 33% of their workday.	**Not at all limited,** individual has no limitations in this area
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Stooping, Kneeling, Squatting &Crouching	☐	☐	☐	☐
Climbing & Balancing	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Seeing	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Remembering	☐	☐	☐	☐
Recognizing	☐	☐	☐	☐

Workday Activity	**Continuously limited,** individual is limited in this activity up to 65-100% of their workday.	**Frequently limited,** individual is limited in this activity up to 34-64% of their workday.	**Occasionally limited,** individual is limited in this activity up to 33% of their workday.	**Not at all limited,** individual has no limitations in this area
Following Instructions	☐	☐	☐	☐
Working	☐	☐	☐	☐
Teaching	☐	☐	☐	☐
Attend/Participate in Meetings	☐	☐	☐	☐
Attention Span	☐	☐	☐	☐
Analyzing	☐	☐	☐	☐
Interacting with Others (this includes students, co-workers and/or customers)	☐	☐	☐	☐
Driving (those who operate a UT vehicle as part of their job)	☐	☐	☐	☐
Lifting, Pushing or Moving 10 or less lbs.	☐	☐	☐	☐
Lifting, Pushing or Moving 10 – 20 lbs.	☐	☐	☐	☐
Lifting, Pushing or Moving 20 - 50 lbs.	☐	☐	☐	☐

Workday Activity	**Continuously limited,** individual is limited in this activity up to 65-100% of their workday.	**Frequently limited,** individual is limited in this activity up to 34-64% of their workday.	**Occasionally limited,** individual is limited in this activity up to 33% of their workday.	**Not at all limited,** individual has no limitations in this area
Lifting, Pushing or Moving 50 - 80 lbs.	☐	☐	☐	☐
Lifting, Pushing or Moving over 80 lbs.	☐	☐	☐	☐
Reaching	☐ Overhead ☐ Above Shoulders	☐ Overhead ☐ Above Shoulders	☐ Overhead ☐ Above Shoulders	☐ Overhead ☐ Above Shoulders
Hand Function: Grasping and/or Squeezing	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right
Hand Function: Writing and/or Holding a Pen/Pencil	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right
Hand Function: Typing and/or Operating a Mouse	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right
Hand Function: Repetitive Hand or Wrist Motions (activities that involve twisting the wrist)	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right
OTHER:(please explain)	☐	☐	☐	☐

8. Describe any recommended accommodations. Be as specific as possible (i.e. a piece of office equipment or device, etc.)

☐ Purchase of Assistive Device(s): _____

_____

☐ Removal of Communications Barrier: _____

_____

☐ Removal of Architectural Barrier:_____

_____

☐ Modified Work Schedule:_____

_____

☐ Job Restructuring (the University is **not** required to reallocate essential job functions):_____

_____

☐ Ergonomic Assessment: _____

_____

☐ Other:_____

_____

9. Describe how the requested accommodations will enable the individual to perform their essential job functions.

10. Please provide any other information that might help the University of Texas at Austin evaluate this request.

Section III: For Completion by the HEALTHCARE PROVIDER

I, the undersigned licensed healthcare provider, certify that the information I have provided regarding the above-referenced individual is complete and accurate to the best of my knowledge. I understand that my cooperation is necessary for the University of Texas at Austin to make an accurate determination regarding my patient's reasonable accommodation request.

Licensed Healthcare Provider's Signature	Date
Print Name	License No.
Phone Number	Fax Number
Email Address	Area of Practice

Submit your response to the questions above via fax at 512-471-8180 or 512-475-7730. The fax should be directed to the attention of The University ADA Coordinators.

If you have questions, please contact the ADA Coordinators at 512-471-1849 or by email at ada@austin.utexas.edu

Section IV: For Completion by the EMPLOYEE

Authorization to Release Medical Information

I,_____, authorize the University's ADA Coordinators (Dr. Jennifer Maedgen/Stephanie Myers) to communicate with my licensed healthcare provider listed below. The purpose of this authorization is to assist my employer, the University of Texas at Austin, in evaluating the need for workplace accommodations.

I authorize my licensed healthcare provider listed below to provide information to the University's ADA Coordinators that will assist the University in making a determination regarding my request for workplace accommodations.

I understand that I may revoke this authorization at any time by notifying in writing the University's ADA Coordinators, but if I do, it will not have any effect on actions the University took in reliance on this authorization prior to receiving the revocation. This authorization expires if the employee no longer seeks workplace accommodations under the Americans with Disabilities Act, as amended or leaves employment with the University.

Contact Information for my Licensed Healthcare Provider:

_____

Healthcare Provider's Name

_____

Healthcare Provider's Mailing Address

_____

Healthcare Provider's Telephone Number Fax Number

_____

Employee Name (print) Date

_____

Employee Signature UT EID

This form can be submitted:

- **Via email at: ada@austin.utexas.edu**
- **By fax at: 512-471-8180 or 512-475-7730**