UNIVERSITY OF MASSACHUSETTS LOWELL
REQUEST FOR REASONABLE ACCOMMODATION

Instructions: ***This form is in three sections. Section I has been completed for you. Section II is for you to complete. Next, present this form, your signed medical release authorization, and your job description to your health care provider. Section III is to be completed by your health care provider. The form should then be returned to Equal Opportunity & Outreach (EOO). After reviewing this request, EOO may contact your health care provider for additional information if further clarification is needed. The medical information obtained in response to this request for accommodation will be maintained by EOO in a file separate from your personnel file.***

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 or family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R 1635.8(b)(1)(B)

I. EMPLOYER INFORMATION:

Name: UNIVERSITY OF MASSACHUSETTS LOWELL, Equal Opportunity & Outreach

Address: Wannalancit Mills Suite #301, 600 Suffolk Street, Lowell, MA 01854
Phone: (978) 934-3566 Fax: (978) 934-3032

Equal Opportunity & Outreach: Mrs. Donna E. Vieweg, ADA Deputy Coordinator

II. TO BE COMPLETED BY EMPLOYEE:

1. Full Name: _____
   First Middle Last
   Address: _____
2. Identify the impairment(s) for which you are requesting a workplace accommodation:
   _____
3. If you have received treatment for this from other providers, please indicate from whom:
   _____
4. Identify and describe the functions of your job that you are unable to perform without a reasonable accommodation: _____

ote : If in the event of an emergency you may require assistance, please ask your health care provider to complete the item beginning "If applicable" at the end of Section III below. Your signature below authorizes EOO to disclose relevant confidential information about your medical condition to first aid or safety personnel. Please contact EOO if you have any questions or concerns.

4. Your signature: _____ Date: _____

III. TO BE COMPLETED BY HEALTH CARE PROVIDER:

Your patient/client identified above is an employee of UMass Lowell, and has requested a workplace accommodation under the Americans with Disabilities Act Amended 2008. He/she has signed the attached Medical Authorization Release Form authorizing the disclosure of his/her medical information in connection with this request for accommodation. Your input is requested below in order that we may evaluate his/her request for accommodation taking into account your professional opinion. ***lease refer only to those impairments for which your client/patient is requesting accommodation (see Section II, item 2 above).*** *After reviewing your input, EOO or your client/patient may contact you for additional information.*

1. Name of health care provider completing this form: _____

License No.: _____ Specialty: _____

2. Mailing Address and Telephone Number: _____

_____

3. lease complete only the checked items below, OR initial this statement if it applies.

_____ **(Initials) I do not have sufficient information regarding this patient/client to complete the checked items below.** ***(If initialed, skip to item 4.)***

☐ DURATION OF IMPAIRMENT(S)
What is the date the impairment commenced for which your patient/client is requesting an accommodation (in Section II.2)? What is the estimated duration of the impairment? _____

☐ NATURE OF IMPAIRMENT(S) Please refer to the attached job description.
Please indicate the major life functions in which your client/patient has impairments which may limit his/her ability to perform the functions of his/her position without accommodation. Major life functions include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working; or the operation of a major bodily function.

_____

_____

☐ FUNCTIONAL LIMITATIONS - Please refer to the attached job description.
Please specify the aspects of the position's functions in which your client/patient is limited without accommodation, and the extent of the limitation. For physical impairments, please specify specific lifting, driving, standing, stair-climbing, walking, etc. limitations in terms of amounts of weight, time, distance, repetition, etc. to which your patient/client is limited without accommodation, or specify environmental factors which limit his/her ability to perform his/her duties. _____

_____

_____

☐ INPUT ON ACCOMMODATIONS - Please refer to the attached job description.
Please describe what in your opinion constitutes the appropriate type or nature of accommodation(s) which would enable your patient/client to fully perform his/her job duties. Please do not refer to specific rooms or work areas.

_____

_____

(section III continues on page 3)

III. (CONTINUED)

If applicable, please describe what assistance your patient/client requires in the event of an emergency. For example, what are the appropriate actions if the client/patient's assistive technology fails to operate properly or if an elevator is temporarily out of service?

If desired, please feel free to provide additional information on letterhead signed by you.

4. Signature of health care provider completing this form:
   Section III of this form is accurate and complete to the best of my knowledge.

   Signed: _____ Date: _____

Please return this form to UMass Lowell, Equal Opportunity & Outreach, at the address listed in Section I.
Thank you for participating in this process.