UNIVERSITY OF MONTEVALLO

COVID-19 REASONABLE ACCOMMODATION

FALL SEMESTER 2020

MEDICAL REQUEST FORM

FOR FACULTY AND STAFF

To: University of Montevallo Faculty and Staff:

- Employee must complete Section I below, provide details about the essential functions of their job.
- Employee must submit this request form to the applicable medical provider, and **request medical provider to complete Section II (Certifying the underlying health condition of the UM employee -- or-- underlying condition of the person for whom UM employee provides primary care.)**
- Completed forms (both sections) are to be returned to the Director of Human Resources/EEO Officer at forrestb@montevallo.edu
  Or
  hr@montevallo.edu or fax: 205-665-6053. For questions, please call 205-665-6055.

Section I: To be completed by employee:

UM EMPLOYEE NAME:	**TITLE:**
DEPARTMENT:	**SUPERVISOR:**
ESSENTIAL JOB FUNCTIONS:	

PATIENT'S FULL NAME (IF NOT THE UM EMPLOYEE):

RELATIONSHIP TO THE UM EMPLOYEE MAKING THIS REQUEST:

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Release of Information

I hereby authorize the release of the following information to the University of Montevallo for the purpose of determining the availability of reasonable workplace accommodations. I further authorize the University of Montevallo to seek clarification from my health care provider of the information submitted by the provider. I understand that I may revoke this authorization in writing at any time, except to the extent that the University of Montevallo has taken action in reliance of this authorization, and if I revoke this authorization, such revocation will not have any effect on disclosures made prior to such revocation. I understand that, if the person(s) or organization(s) that I authorize to receive my health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws. I acknowledge that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility for benefits on whether or not the authorization is signed. I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this form shall have the same legal validity as the original.

_____ _____

Signature **Date**

Section II: To be completed by the physician or health care provider.

To Physician or Health Care Provider:

To initiate a request for reasonable accommodations, employees must provide current documentation of their own underlying medical condition or that of the family member for whom they provide primary care, if such condition or care may warrant reasonable accommodations. As the physician or healthcare provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary.

To complete this form, you should consider the employee's job functions and other information relevant to the employee's job at the University of Montevallo. If this information has not been provided, please contact the employee and let him or her know you cannot complete this form without that information.

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. Thank you for your assistance.

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1. What is the underlying condition for which an accommodation is being requested?

_____ Serious Heart Condition	_____ Chronic Lung Disease/Moderate to Severe Asthma
_____ Severe Obesity (BMI > 30)	_____ Chronic Kidney Disease Undergoing Dialysis
_____ Liver Disease	_____ Diabetes
_____ Immunocompromised	_____ Hemoglobin Disorders
_____Other - Please Specify	

2. What accommodations are you recommending for the UM employee? Please identify reasonable accommodations that would allow this employee to perform the essential functions of his or her job.

LIST EACH REASONABLE ACCOMMODATION	DURATION ACCOMMODATION EXPECTED TO BE NEEDED

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LIST EACH REASONABLE ACCOMMODATION	DURATION ACCOMMODATION EXPECTED TO BE NEEDED

3. Provider Information:

_____ _____

Signature of Health Care Provider **Date**

_____ _____

Provider Name (Printed) **Name and Location of Practice**

_____ _____

Telephone Number of Provider **Fax Number and Email Address of Provider**