UW Health

Reasonable Accommodation Request

Following this cover letter, you will find three (3) forms, each one is explained further below.

1) Employee Request for Reasonable Accommodation: Form filled out by an employee when they would like to request a reasonable accommodation. When completing the form, please be detailed and specific, as this information will be used to determine the appropriate course of action for your situation.

2) Medical Provider Report: To ensure we fully understand your request we will need to obtain medical documentation from your treating provider to evaluate the request under the Disability Acts. It will be important for your provider to review a copy of your current position description, which should be submitted with the Medical Provider Report form. Job descriptions are available on The Pulse. If you need assistance locating your position description, please contact the HR Service Center at 608.263.6500.

3) Release of Medical Information: By completing this form, you are authorizing UW Health Employee Relations, UW Health Provider Services, and/or Employee Health Services to speak to and/or correspond directly with your treating provider(s) regarding your reasonable accommodation request. Completion and submission of this form is voluntary.

Please return all forms to UW Health's HR Service Center, Attn: Employee Relations or Provider Services **within 15 calendar days of your request.** If a delay in the return of these forms or the supporting medical documentation is expected, or if you do not wish to pursue an accommodation at this time, please let your Employee Relations Consultant (ERC) or Provider Services Consultant (PSC) know. Should you have any questions, please contact your ERC or PSC directly or via the HR Service Center at 608-263-6500.

UWHealth

Employee Request for Reasonable Accommodation

Employee Name: _____ **Employee ID#:** _____ **Request Date:** _____

Work Location: _____ **Department:** _____

Job Title: _____ **Direct Leader:** _____

To be eligible for a reasonable accommodation under the Americans with Disabilities Acts (ADA/ADAAA) and/or the Wisconsin Fair Employment Act (WFEA), you must be qualified to perform the essential functions or "adequately" perform the job responsibilities of your position with or without an accommodation and have a qualifying disability that limits a major life function. If you would like to be considered for a reasonable accommodation, please complete this voluntary form as completely as possible.

Information that you submit will be kept confidential except that (1) Accommodations needed or restrictions on the work or duties will be reported to your leader; (2) Employee Health Services, first aid and safety personnel may also be informed, when appropriate, if the disability might require emergency treatment; (3) Government officials investigating compliance with ADA shall be provided relevant information on request; (4) Agencies administering State workers' compensation laws, as required.

1. Please describe your physical or mental impairment and how it affects your ability to perform your job duties.

2. Please describe the specific accommodation(s) you are requesting.

3. Additional comments:

Employee Signature: _____

Date: _____

Initial to confirm a copy of your job description will be submitted with Medical Provider Report form below: _____
(Failure to submit a copy of the job description may delay their ability to complete required form.)

Send completed forms to:

Email (preferred):	**If email is not an option, forms may be faxed to:**
HREmpRelations@uwhealth.org	608-263-5778 Attn: Employee Relations

Medical Provider Report for Accommodation

Date: _____

Patient Name: _____ **Date of Birth:** _____

Patient's Job Title: _____

Under the Americans with Disabilities Acts, an employee has a disability if they have a physical or mental impairment that substantially limits one or more major life activities or has a record of such impairment.

Please answer the following questions so UW Health may appropriately evaluate the employee's accommodation request in accordance with Disability Acts.

Send completed forms back (**e-mail is preferred**):

Email Forms to:	**If email is not an option, forms may be faxed to:**
HREmpRelations@uwhealth.org	608-263-5778 Attn: Employee Relations

1. What is the individual's physical or mental impairment for which an accommodation is being requested?

a. Name of physical or medical impairment: _____

b. Approximate date condition commenced? _____

2. Does this impairment substantially limit one or more major life activities as compared to most people in the general population? ☐ No ☐ Yes (please select major life activity(s) and/or major bodily functions affected):

Major life activities *include but are not limited to:*		***Major bodily functions*** *include but are not limited to:*	
☐ Bending	☐ Reaching	☐ Bladder	☐ Immune
☐ Breathing	☐ Reading	☐ Bowel	☐ Lymphatic
☐ Caring for oneself	☐ Seeing	☐ Brain	☐ Musculoskeletal
☐ Communicating	☐ Sitting	☐ Cardiovascular	☐ Normal cell growth
☐ Concentrating	☐ Sleeping	☐ Circulatory	☐ Operation of an organ
☐ Eating	☐ Speaking	☐ Digestive	☐ Reproductive
☐ Hearing	☐ Standing	☐ Endocrine	☐ Respiratory
☐ Interacting with others	☐ Thinking	☐ Genitourinary	☐ Special sense organs
☐ Learning	☐ Walking	☐ Neurological	☐ Skin
☐ Lifting	☐ Other: _____	☐ Hemic	☐ Other: _____
☐ Performing manual tasks			

3. Describe the nature, severity, and anticipated duration of this impairment.

☐ Temporary (explain): _____

- Anticipated healing period: _____

☐ Permanent

☐ Chronic (explain): _____

4. Please review the enclosed job description and respond to the questions below. Please provide as much detail as necessary to support these limitations.

a. What functional limitations does this impairment place on this individual's ability to perform the essential functions of the job?

b. How do the functional limitations listed impact the individual's ability to perform the essential functions of the job?

c. Please complete the following if the individual has physical restrictions:

	Frequency of Movement Performed				
	Never 0% 0 hours/day	**Occasionally 1-33% up to 3 hours/day**	**Frequently 34-66% 3-5 hours/day**	**Constantly 67-100% 5-8 hours/day**	**Comments**
Lifting ___ lbs. (max weight)					
Repetitive lifting ____ lbs.					
Carrying ____ lbs.					
Pushing/pulling ____ lbs.					
Grasping/squeezing ____ lbs.					
Reaching above shoulder (circle) R/L					
Reaching away from body					
Crawling					
Squatting/kneeling					
Climbing					
Twisting					
Bending					
Sitting					
Walking ____hours per day					
Speaking ____hours per day					
Standing ____hours per day					
Sitting ____hours per day					
Driving ____hours per day					

5. What suggested accommodations are you recommending that would enable this individual to continue or begin performing their job with any of the above limitations you described? If the recommendation is for additional time off work (for medical episodes and/or appointments) please ensure frequency and/or duration is provided. Please explain. (Attach a separate page if preferred.)

Impairment	Restriction	Suggested Accommodation

_____ _____
Signature of Health Care Provider Name of Health Care Provider (Please Print)

_____ _____
Type of Practice Address

(___)_____ (___)_____
Phone Number Fax Number

_____ _____
Email Date Completed

GINA Restrictions: 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" 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.

RELEASE OF MEDICAL INFORMATION FOR DISABILITY ACCOMMODATION REQUESTS

Please complete all sections of this form. ***Completion of this form is voluntary.*** *By completing this document, you demonstrate informed consent and authorization to allow your medical provider to release and disclose to UW Health Human Resources – Employee Relations/Provider Services and Employee Health Services such health care records and information concerning your current medical condition as is necessary to support your request for potential disability accommodations.*

1. Employee Information

Name (Last, First, MI):	Birthdate:	Medical Record # (if known):	
Street Address:	City:	State:	Zip:

2. Exchange of Information between the following: (Name of healthcare provider i.e., UW Health, SSM, GHC, UnityPoint Health - Meriter)

Name (e.g. Health Facility, Physician or Provider):			
Address:	City:	State:	Zip:

3. And:

UW Health/Human Resources – Employee Relations or Provider Services		UW Health/Employee Health Services Dept.	
Address: 7974 UW Health Ct		Address: 700 University Bay Dr. Suite 101	
City/State/Zip: Middleton, WI 53562		City/State/Zip: Madison, WI 53505	
Email: HREmpRelations@uwhealth.org	Phone Number: 608.263.6500 Fax Number: 608.263.5778	Email: HREmployeeHealth@uwhealth.org	Phone Number: 608.263.7535 Fax Number: 608.262.7284

Information to be disclosed is limited to such health care records and information concerning my current medical condition as is necessary to support my request for potential disability accommodations. Format of information to be disclosed (***please check at least one box***):

☐ **Written Medical Record Documentation**

☐ **Verbal Communication of Medical Record between parties listed above.**

This authorization is made per my request. This authorization shall be valid for one (1) year from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization. Revocations must be made in writing and submitted to UW Health Human Resources - Employee Relations via fax to 608-263-5778 or e-mail HREmpRelations@uwhealth.org. I understand that information disclosed by the physician or practitioner to the employer may be subject to re-disclosure and not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I also understand that in accordance with the Genetic Information Non-Discrimination Act UW Health is not requesting nor should the health care provider furnish any information related to my family medical history, alcohol or drug treatment, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results.

Signature of Employee: _____ **Date:** _____