University of Tennessee, Knoxville **FORM 2**
Employees (Faculty and Staff)
Medical Information Request Form

Introduction:

University of Tennessee, Knoxville area employees requesting a reasonable accommodation at the workplace based on a disability must submit:

- The completed Request for Reasonable Accommodations form, filled out by the employee (Form 1); and
- this form, the Medical Information Request form, filled out by the employee's physician or health care provider (Form 2).
- Both completed forms must be returned to: ADA Coordinator, Office of Equity and Diversity, 1840 Melrose Ave., The University of Tennessee, Knoxville, TN 37996-3560.
- Forms may also be faxed to: (865) 974-0943
- For questions, please call (865) 974-2498

Section 1: To be completed by employee

_____ _____
Employee Name Job Title

_____ _____
Department Supervisor

Section 2: Release of Information (to be completed by employee)

I give permission to my health care providers to release the following information to the University of Tennessee, Knoxville, to assist the University in determining whether, and to what extent, I may be eligible for a reasonable accommodation at the workplace.

I further give my health care providers permission to discuss my health conditions with the University of Tennessee, Knoxville, if necessary for clarification purposes.

_____ _____
Employee Signature Date

Employee Name: _____

Section 3: To be completed by the physician or health care provider

The University of Tennessee (University) employee named above has requested that the University provide him/her with a reasonable accommodation at the workplace based on a disability. A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. An employee making such a request must provide the University with current documentation of a disability. You are being asked by the employee to provide documentation by fully completing all sections of this form. These questions will help determine 1) whether the employee has a disability, 2) whether an accommodation is needed, and 3) what options may exist that would constitute an effective, reasonable accommodation.

The employee should provide you with a copy of his or her job description and functions. Please review the job description and functions, and any other information relative to the employee's work at the University in order to complete this form. The completed form may be returned to the employee, or may be mailed or faxed to the address listed in the introductory paragraph.

1. Please identify the employee's physical or mental impairment(s):

2. Please describe the effects or limitations this impairment has on the employee's activities, if any:

3. Please describe whether the effects or limitations are long-term, permanent, or short-term.

4. Please review the information supplied by the employee concerning his or her job duties. What limitation(s) is interfering with the employee's job performance?

5. Please describe what job functions the employee is having trouble performing because of the limitations:

6. How does the employee's limitation(s) interfere with his or her ability to perform the job?

7. Are there any activities or job duties that would present a health or safety risk to the employee or others due to the impairment or its treatment?

8. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

9. Any additional comments?

_____ _____
Signature of physician or care provider Date

_____ _____
Provider name (printed) Telephone #

_____
Provider Address

_____

_____

Last updated 8/09