Employee Accommodation Request Form
Americans with Disabilities Act (ADA)

Section I: For Completion by the Employee

Employee Name:	Date:
E-mail Address:	TCU ID Number:
Building:	Office Extension:
Job Title:	Cell Phone:
Supervisor:	Department:
Regular Work Schedule:	Job Description is: Attached ☐ Not Attached ☐

Section II: For Completion by the Health Care Provider

Instructions to the Physician:

A request for a reasonable accommodation has been made by our employee,_____.In order to assist with this interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions to help determine disability and reasonable accommodation.

Background

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities, or has record of such an impairment. "Substantially limits" under the ADA has been broadened to allow someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.

The Americans with Disabilities Act (ADA) provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

Provider Name (please print): _____

Type of Practice / Medical Specialty: _____

Business Address: _____

Phone: _____ Fax: _____

Section II: For Completion by the Health Care Provider

1. Does the employee have a physical or mental impairment? _____Yes_____No

2. Please describe the medical condition for which the employee is requesting an accommodation.

_____

_____

3. When did this medical condition begin? _____

4. How long is it expected to last? _____

5. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the medical condition or accompanying treatment.

_____

_____

6a. Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential duties and typical schedule.)
Is the employee able to perform the essential functions of his/her position in a typical schedule with, or without, reasonable accommodation?

_____ Yes, with reasonable accommodation
_____ Yes, without reasonable accommodation
_____ No, they are unable to perform their essential job functions with or without accommodation

6b. If *Yes,* what adjustments to the work environment or position responsibilities would enable the employee to perform these job functions?

_____

_____

6c. If *Yes,* how long will the employee need the reasonable accommodation to perform these job functions?
_____# of weeks _____# of months _____permanently

6d. If *No,* how long will the employee remain unable to perform these job functions?
_____# of weeks _____# of months _____permanently

_____

7. Additional Comments or Suggestions:

Health Care Provider Signature:	Date:
When form is complete, please either:	Mail: Texas Christian University, Human Resources, TCU Box 298200, Fort Worth, TX 76129; Fax: (817) 257-3652 E-mail: fmla/ada@tcu.edu
If you have any question, please contact:	fmla/ada@tcu.edu or (817) 257-7790