CIVIL RIGHTS COMPLIANCE AND PREVENTION EDUCATION
VIRGINIA TECH

ADA Accommodation Request form

ADA & ACCESSIBILITY SERVICES
Office for Civil Rights Compliance and Prevention Education (CRCPE)
220 Gilbert St. Suite 5200 Blacksburg, VA 24060
Phone: 540-231-0897 | Fax: 540-231-2990
adaaccess@vt.edu

What is the ADA accommodations interactive process?

1. An accommodation specialist will review the returned documentation and your position description, determine reasonable accommodations and confirm those accommodations with the employee.
2. Once the specialist receives confirmation from the employee, the specialist would ask for concerns from the supervisor or accommodation designee.
3. If the supervisor has no concerns, an authorization letter for the accommodations will be sent out to you, your supervisor and a Human Resources representative for your department (if any exists).
4. If the supervisor has concerns where the accommodation would present undue hardship, the specialist will reach out to you to discuss alternative reasonable accommodations.

Your medical information during this process is kept confidential and is only shared between you, the ADA case manager and the accommodation specialist assigned to your case.

What are the employee's responsibilities when requesting an accommodation?

1. Engage in the interactive process with ADA and Accessibility Services.
2. Obtain relevant medical documentation from the medical provider and providing the medical documentation to ADA and Accessibility Services.
3. Must be able to perform all the essential functions of their position with or without reasonable accommodation.
4. Adhere to the accommodations authorized through the interactive process.
5. Provide ADA & Accessibility Services with an updated Medical Information Request form if there is a need to renew a temporarily authorized accommodation or review a current accommodation.
6. Notify ADA & Accessibility Services if the authorized accommodation is not effective.
7. Notify ADA & Accessibility Services if the authorized accommodation is no longer needed.
8. Notify ADA & Accessibility Services if there is a change to their supervisor or position.

ADA and Accessibility Services

Authorization to Receive Medical Information from Treating Health Care Professional

This form will be used by Virginia Polytechnic Institute and State University ADA and Accessibility Services to determine whether this employee qualifies for accommodations under the Americans with Disabilities Act.

(To be completed by Virginia Tech Employee)

Name of Employee _____

Hokie ID No. _____ DOB _____ Ph. No. _____

Position _____ Email Address _____

Mailing Address _____

Supervisor _____ Dept. _____

I give ADA and Accessibility Services at Virginia Polytechnic Institute and State University permission to receive information and/or contact the following treating professional.

Name of Treating Health Care Professional _____

Name of Practice _____

Address _____ City _____ St _____

Zip _____ Phone _____ Fax _____

GINA Notice: 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.

- I understand the reason for this contact is to advise ADA and Accessibility Services at Virginia Tech as to my functional abilities and limitations with regards to my job functions.
- I understand that ADA and Accessibility Services may provide the above listed professional with specific information about my job position, including the essential functions of my job, and specific requirements. All medical information will be maintained and used in accordance with ADA confidentiality requirements.

_____ _____

(Employee Signature) (Date)

PLEASE EMAIL, MAIL, OR FAX THIS COMPLETED FORM TO:

ADA and Accessibility Services Attn: Accommodation Fax # 540-231-2990 adaaccess@vt.edu

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(To be completed by Virginia Tech Employee prior to sending form to Treating Medical Provider)

Name of Employee _____

Hokie ID _____ DOB _____ Phone No. _____

Supervisor _____ Dept. _____

Position _____ Email Address _____

Mailing Address _____

(To be completed by Employee's Treating Medical Provider)

1. What is the specific diagnosis or condition?

_____

   a. Nature of the condition? _____

2. Are you currently treating the individual for the specific diagnosis or condition? ☐ Yes ☐ No
   a. If no, has the employee been referred to other health care provider(s) for evaluation or treatment? ☐ Yes ☐ No
   b. If yes, referred to _____

3. Expected Duration: ☐ Temporary ☐ Permanent/Ongoing ☐ Episodic
   If temporary, effective until ___/___/___ *(substantially limiting when active)*

4. What is the severity? ☐ Mild ☐ Moderate ☐ Severe
5. Chronic condition? ☐ Yes ☐ No
   a. Long-term prognosis of this condition? _____
6. Affects a major life activity: ☐ Yes ☐ No If yes, what major life activity(s) is/are limited?

(Examples: walking – speaking - breathing – hearing – seeing – working – standing – immune system– sleeping – learning –memory – thinking – major bodily functions – concentration - caring for oneself - performing manual tasks - interacting with others- endocrine system - reproductive system.)

_____

_____

7. Does this patient experience side effects from the medication? ☐ Yes ☐ No If yes, please describe.

_____

_____

8. Current medical restrictions based on employee's ***current*** capabilities:

Physical

Restrict Movement of the Spinal Column: ☐ No Restrictions

Lower Back: ☐Bending forward ☐Bending backward ☐Twisting Side bending
☐Upper Back: ☐Bending forward ☐Bending backward ☐Twisting Side bending
Neck: ☐Bending forward ☐Looking up Rotation Side bending
Additional Information:_____

Restrict Sitting Activities: ☐No Restrictions

☐Desk work (reading, writing) - _____hours/day ☐Meetings -_____ hours/day
☐Telephone use (with headset) - _____% of day ☐Computer work - _____ hours/day
☐Driving -_____ hours/day ☐Other - _____ hours/day
Additional Information:_____

_____

Restrict Standing Activities: ☐No Restrictions

In an 8 hour workday, the employee cannot:
☐ Stand more than 0 2 4 6 8 hours per day
☐ Walk more than 0 2 4 6 8 hours per day
☐Balancing ☐Stooping ☐Crouching ☐Squatting ☐Kneeling ☐Crawling ☐Climbing
☐Stairs ☐Operating general office equipment (e.g., printer, photocopier, paper cutter)
Additional Information:_____

Restrict Lifting / Carrying / Pushing / Pulling: ☐No Restrictions

☐Lifting Min_____Max_____ ☐Carrying Min_____Max_____
☐Pushing Min_____Max_____ ☐Pulling Min_____Max_____
Additional Information:_____

Restrict Working with Shoulders / Elbows / Wrists / Hands / Fingers: ☐No Restrictions

Reaching: ☐Above shoulder level ☐Below shoulder level ☐At shoulder level
Handling: ☐Fine objects ☐Tools/Objects requiring strong hand grip ☐Vibrating tools/objects
☐Using Computer Mouse ☐Filing ☐Fingering
☐Writing ___hrs/day ☐Typing _____ hrs/day
Additional Information:_____

9. Do you have any suggestions regarding possible accommodations to assist with the employee's job functions?

10. How would your suggestions assist the employee's job functions?

11. Other comments:

Medical Certification

In your professional medical opinion, the named employee is able to return to work with the stated medical restrictions.

Certification: This form must be completed and signed by the appropriate medical treating professional. If a stamp is not available, this form should be accompanied by a business card or letterhead paper.

Medical Physician's Signature: _____

Name _____ Title _____ Specialty _____

Name of Practice _____

Date _____ Phone _____ Fax _____

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