Print Form

Human Resource Services

University of Northern Iowa

Workplace Accommodation Medical Certification

Section I: Authorization for Release of Information

Employee Name | **Job Title**

Department | **Supervisor**

I hereby authorize the release of the following information to University of Northern Iowa Human Resource Services for the purpose of determining the availability of reasonable workplace accommodations. I further authorize University of Northern Iowa Human Resource Services to seek clarification of this documentation if necessary by contacting the healthcare provider completing this certification.

Signature | **University ID** | **Date**

Section II: Healthcare Provider Instructions

A request for an accommodation has been made by our employee. In order to assist with the interactive process, we are requesting you provide responses to the questions on page 2 based on your medical expertise and knowledge of the employee's health condition.

To be eligible for an accommodation under the ADA, an employee must have an impairment that substantially limits one or more major life activities. The employee must also be qualified to perform the essential functions of their job, with or without an accommodation. Your feedback will assist us in determining whether this employee meets these qualifications.

Please review the employee's job description and other information relevant to the employee's position at the University of Northern Iowa. If those materials have not been provided, please discuss the position with the employee to determine essential job duties and typical schedule or request a copy from our office.

Thank you for your assistance.

To comply with The Genetic Information Nondiscrimination Act of 2008 (GINA), please do not provide any genetic information when responding to this request for medical information. *"Genetic Information" includes and individuals 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.*

Note: Please return completed form to: UNI Human Resource Services, **Fax: 319.273.2430**

Section III: Healthcare Provider Certification

1. Does the employee have a physical or mental impairment that substantially limits major life activities?
   No ☐ Yes ☐ ▸ If **Yes**, what is the impairment?

2. Does the impairment substantially limit a major life activity as compared to most people in the general population?
   No ☐ Yes ☐ ▸ If **Yes**, what major life activity/activities is/are affected?

3. What limitation(s) is/are interfering with employee's job performance?

   a. How long do you anticipate the limitation(s) will exist?

4. What job functions is the employee having trouble performing because of the limitation(s)?

5. How does the employee's limitation(s) interfere with their ability to perform their job functions?

6. Do you have any suggestions regarding possible accommodations to enable the employee to perform their essential job functions?
   No ☐ Yes ☐ ▸ If **Yes**, please identify the suggested accommodations and the anticipated duration of the employee's need below:

Section IV: Healthcare Provider Information

Healthcare Provider Name: _____

Type of Practice/Specialty: _____ Phone: _____

Address: _____

Healthcare Provider Signature: _____ Date: _____