Office of Affirmative Action

Employee Disability Accommodations – Healthcare Provider Information Form

The following information is being requested as part of the interactive accommodations process, used by the University of Missouri-Kansas City to determine if an employee is a person with a disability as defined by the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA) and whether they are eligible to receive accommodation(s) under the ADA.

This form will be kept private and shared only with staff of the Office of Affirmative Action. If you have any questions about completing this form or would like to submit a different type of medical documentation other than this form, please contact Lacie McClellan-Fox, Employee ADA Specialist, at lj.mcclellan-fox@umkc.edu or ljm4b7@umsystem.edu or call (816) 235-6522.

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 employees or their family members. In order 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.

Employee Name: ______________________________________________

A. Determination of Disability

Definition: An employee has a disability and may be eligible for reasonable accommodations in the workplace if they have an impairment that substantially limits one or more major life activities. The following questions are to assist in determining whether an employee has a disability.

Does the employee have a physical or mental impairment?   Yes   No

If yes, what is the impairment/diagnosis?   ________________________________

Is the impairment permanent, chronic, or of indefinite duration?   Yes   No

If not permanent/chronic/indefinite, what is the anticipated duration of the impairment?   ______________

Does the impairment substantially limit* one or more major life activities?   Yes   No

Examples include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working.

*As compared to a majority of the general population
If yes, please provide a detailed explanation:

B. Accommodations Recommendations
The Office of Affirmative Action will collaboratively engage in an interactive process with the employee and their supervisor(s) to determine reasonable accommodations, and recommendations from health care providers are valuable in determining the employee’s needs. If there are workplace modifications that you believe would be reasonable, please share these below, as well as any alternatives that may be considered similarly reasonable.

C. Additional Comments

Healthcare Provider Printed Name: __________________________________________
Healthcare Provider Signature: ____________________________________________ Date: ____________
Address: ________________________________________________________________
Email: ________________________________________________________________
Phone Number: _________________________________________________________

Please return completed form or alternate document with requested information to Lacie McClellan-Fox at lj mcclellan foxumedu or ljm4b7@umsystemedu or provide the completed form to the employee to deliver to the Office of Affirmative Action.