THE UNIVERSITY OF CHICAGO | Office of the Provost
Equal Opportunity Programs

Medical Provider Form

This form is to be completed by a certified health professional for a University of Chicago faculty, an other academic appointee, or a postdoctoral researcher.

Equal Opportunity Programs reviews accommodation requests made by faculty, other academic appointees, and postdoctoral researchers with disabilities. EOP approves effective reasonable accommodations that enable faculty, other academic appointees, and postdoctoral researchers with disabilities to perform all of the essential functions of their job unless the accommodation requested would cause undue hardship.

In certain circumstances, particularly where the disability and/or need for accommodation is not obvious, EOP will request that the faculty, other academic appointee, or postdoctoral researcher provide reasonable documentation from their provider to establish that the person has a disability and that the disability requires a reasonable accommodation under the Americans with Disabilities Act (ADA). The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities. Further, under the ADA, a reasonable accommodation is any change to the work environment or in the way things are done that enable a person with a disability to perform their essential job functions. Accommodations may include (but are not limited to): making existing facilities accessible, job restructuring, part-time or modified work schedules, acquiring or modifying equipment, changing tests, training materials, or policies, providing qualified readers or interpreters, and reassignment to a vacant position. A reasonable accommodation may not impose undue hardship, meaning, that they should not be unduly costly, extensive, disruptive, fundamentally alter the nature or operation of the work, or violate an existing Collective Bargaining Agreement. Also, an accommodation is not reasonable if it seeks to remove or fundamentally alter any essential job function. To standardize the gathering of such information, EOP asks that the provider complete this form.

Faculty/ Other Academic Appointee/ Postdoctoral Researcher Consent
(for completion by faculty, other academic appointee, or postdoctoral researcher)

Faculty/ Other Academic Appointee/ Postdoctoral Researcher Name: _____

I, _____, authorize my health-care provider above to release medical information requested in this form to Equal Opportunity Programs. The medical information requested on this form is used to determine eligibility for reasonable accommodation for my disability while a faculty, other academic appointee, or postdoctoral researcher at the University of Chicago.

Signature of Faculty/ Other Academic Appointee/ Postdoctoral Researcher:
Date:_____

Faculty/ Other Academic Appointee/ Postdoctoral Researcher Position Description

(for completion by faculty, other academic appointee, or postdoctoral researcher)

Job Title _____

Job Summary (provide a description of your key responsibilities or submit a copy of your job description (additional information may be provided by your academic affairs representative or the Office of the Provost) _____

_____

_____

Certifier Information

(for completion by provider)

Clinician Name _____ Clinician Signature _____

Medical Specialty_____

License/Certification # _____ Issuing State _____

Phone _____Email Address _____

Street Address or website of Practice _____

Date of Form Completion: _____

Patient Information

Date of initial contact with patient _____

Date of most recent contact with patient _____

Approximate frequency of contact with the patient since initial contact:

_____

Please describe the nature of the patient's condition.

_____

_____

Please provide any relevant information regarding the duration of the condition.

Describe the functional limitations resulting from this condition (e.g., physical, cognitive, perceptual abilities).

Describe the severity of the limitations and the impact on performing tasks in daily living (e.g. inability to walk farther than 50 feet, unable to drive).

Describe any current and/or anticipated impact in the workplace considering the patient's essential job responsibilities (e.g., headaches caused by computer glare, fatigue).

If the patient is undergoing treatment, please describe how the treatment may affect the condition and/or result in side effects that will impact the patient in the workplace considering the patient's essential job responsibilities.

If the patient is taking medication, please describe how the medication may mitigate the symptoms of the condition and/or result in side effects that may impact the patient in the workplace considering the patient's essential job responsibilities.

Please offer specific recommendations for reasonable accommodations (*e.g.*, workplace modifications or adjustments), which based on your assessment of the aforementioned functional limitation(s), will enable the patient to perform the essential functions of their job.

Please provide any additional information that you think will be useful in evaluating the nature and severity of your patient's disability that will inform the determination of eligibility for disability services and accommodation.

Please return this form to accessuchicago@uchicago.edu.
Phone 773.834.3988 Fax 773.834.0194
Attn: Access UChicago Equal Opportunity Programs/ CONFIDENTIAL