

**REQUEST FOR REASONABLE ACCOMMODATION  
HEALTH CARE PROVIDER EVALUATION**

*To be completed by Health Care Provider Only*



**Office of Accessibility  
and ADA Education**

University of Missouri

**Instructions:**

**The following information is being requested in order 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 Accessibility and ADA Office staff. If you have any questions about completing this form or would like to request the ability to submit a different type of medical documentation other than this form, please contact the ADA Coordinator at [cheeka@missouri.edu](mailto:cheeka@missouri.edu) or 573-884-7278.

*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 of Disability:** An employee has a disability and may be eligible for workplace reasonable accommodations if he or she has 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, or of indefinite duration?  Yes  No

If not indefinite, what is the anticipated duration of the impairment? \_\_\_\_\_

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

*Note: The impairment does not need to significantly or severely restrict the person's activities to meet the standard of being substantially limiting.*

If yes, explain:



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**B. Accommodation Recommendations (if known):**

*Note: the ADA Office will collaboratively engage in an interactive process with the employee and his/her supervisor(s) to determine reasonable accommodations including, and perhaps beyond those included on this form, but recommendations from health care providers are valuable in determining the employee's needs.*

**C. Additional Comments:**

Medical Provider Signature: \_\_\_\_\_

Medical Provider Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

**Delivery Instructions for Health Provider:** Please send the completed form as an email attachment directly to [cheeka@missouri.edu](mailto:cheeka@missouri.edu), or provide the completed form to the employee to deliver to the Office of Accessibility and ADA.

