Human Resources

 100 Morrissey Boulevard

 Boston, MA 02125-3393

 P: 617-287-5150

 F: 617-287-5179

**Request for Accommodation Form**

**Instructions:** This Request for Accommodation form contains 3 parts. Section I has been completed for you. Section II is to be completed by you, the employee. You must present this form, along with your signed *Authorization for Release of Medical Information*, and your job description to your health care provider for completion. Section III must be completed by your health care provider. Upon completion of the 3 sections, please submit the form to Susan D’Amato, Senior HR Generalist, in the Office of Human Resources (HR), via email or hand-delivery. After reviewing your request, HR may contact your health care provider for additional information, if further clarification is needed. The medical information obtained in response to this request will be maintained in a file separate from your personnel file.

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 information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about the manifestation of a disease or disorder in an individual's family members (i.e. family medical history). Genetic information also includes an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual, and the genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

**SECTION I: EMPLOYER INFORMATION:**

Name: UNIVERSITY OF MASSACHUSETTS BOSTON, Human Resources

Address: 100 Morrissey Boulevard, Dorchester, MA 02125

Phone: 617-287-5150 Fax: 617-287-5179

Attn: Susan M. D’Amato, Senior HR Generalist

 **SECTION II: TO BE COMPLETED BY EMPLOYEE**

Full Name:

Job Title: Department:

## Phone: Email:

Supervisor Name and Title:

Supervisor Email:

1. Identify the impairment(s) for which you are requesting a workplace accommodation.

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1. If you have received treatment for this impairment(s) from other providers, please indicate from whom:

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1. Identify and describe the functions of your job that you are unable to perform without a reasonable accommodation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Signature of the Requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

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# SECTION III: TO BE COMPLETED BY HEALTH CARE PROVIDER

Name of Health Care Provider completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date the impairment commenced for which your client/patient is requesting an accommodation (as identified in Section II):

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The anticipated duration of the impairment, if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Nature of Impairment(s): Please refer to attached job description and/or employee’s description of job. Please indicate the major life functions in which your client/patient has impairment(s) which may limit their ability to perform the functions of their job without accommodation. Major life functions include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working.

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1. Functional Limitations: Please refer to the attached job description and/or employee’s description of job to specify the aspects of the position’s functions in which your patient is limited without accommodation and the extent of the limitation. For physical impairments, please specify specific lifting, driving, standing, stair climbing, walking, etc., limitations in terms of the amount of weight, time, distance, repetition, etc., in which your patient is limited without accommodation, or specify environmental factors which limit their ability to perform their duties, if applicable.

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1. Input on Accommodations: Please refer to the attached job description and/or employee’s description of job to describe what, in your opinion, constitutes the appropriate type or nature of accommodation(s) which would enable your patient to fully perform their job duties.

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**Signature of Health Care Provider completing this form**:

Section III of this form is accurate and complete to the best of my knowledge.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this form to Susan M. D’Amato, Sr. HR Generalist, at the address listed above in Section 1 or via email at susan.damato@umb.edu .