Request for Reasonable Accommodation
Health Care Provider Evaluation
To be completed by Health Care Provider Only

Employee Name: ________________________________________

Address: ____________________________________________

The following information is being requested in order to determine if the above employee has a disability as defined by the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA) and is eligible to receive accommodation(s) under the ADA and the ADAAA.

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.

A. Determination of Disability

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities or has a record of such impairment. 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? □ Yes □ No

If not permanent, what is the anticipated duration of the impairment? ________________

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

If yes, what major life activity(s)?

<table>
<thead>
<tr>
<th></th>
<th>Lifting</th>
<th>Walking</th>
<th>Hearing</th>
<th>Caring for Self</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sleeping</td>
<td>Standing</td>
<td>Seeing</td>
<td>Eating</td>
</tr>
<tr>
<td></td>
<td>Concentrating</td>
<td>Reaching</td>
<td>Speaking</td>
<td>Performing manual tasks</td>
</tr>
<tr>
<td></td>
<td>Breathing</td>
<td>Thinking</td>
<td>Learning</td>
<td>Sitting</td>
</tr>
<tr>
<td></td>
<td>Working</td>
<td></td>
<td></td>
<td>Other(specify)</td>
</tr>
</tbody>
</table>
Please describe how the major life activity (ies) checked above are substantially limited.

<table>
<thead>
<tr>
<th>Immune</th>
<th>Genitourinary</th>
<th>Circulatory</th>
<th>Special sense organs/skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemic</td>
<td>Lymphatic</td>
<td>Endocrine</td>
<td>Normal cell growth</td>
</tr>
<tr>
<td>Digestive</td>
<td>Neurological</td>
<td>Reproductive</td>
<td>Other</td>
</tr>
<tr>
<td>Bowel</td>
<td>Brain</td>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Bladder</td>
<td>Respiratory</td>
<td>Cardiovascular</td>
<td></td>
</tr>
</tbody>
</table>

B. Accommodations

How does the employee’s limitation(s) interfere(s) with the employee’s ability to perform the essential functions of the position? *(See job description)*
C. Describe, in detail, how the employee's impairment(s) substantially interfere(s) with the major life activity of "working," that is the employee's capacity to perform the essential functions of their job description.

D. Taking into consideration the nature, severity, and duration of the impairment, the limitations imposed by the impairment, and the effect of the impairment on the employee's ability to perform the essential functions of the position, what alterations to the employee's duties, if any, may assist the employee in effectively performing the essential functions of the position (e.g. alternative scheduling, scheduled breaks, adaptive equipment, movement/effort restrictions, physical changes to the workplace or equipment etc.)?

Medical Provider Name (Print or Type)

Medical Provider Signature

Practice Name

City __________________________ State __________ Zip __________

Telephone ______________________

Fax: __________________________

Return Form to:

Office of Equal Opportunity & Diversity
Human Resources
Prairie View A&M University
Harrington Science Building, Suite 109
P.O. Box 519, Mail Stop 1337
Prairie View, TX 77446-0519
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