

**UNIVERSITY OF MASSACHUSETTS LOWELL  
REQUEST FOR REASONABLE ACCOMMODATION**

***Instructions to UMass Lowell Employee and their Health Care Provider: This form is in three sections.***

- ***Section I provides the contact information for Equal Opportunity & Outreach (EEO) at UMass Lowell, which reviews employee ADA requests for reasonable accommodation.***
- ***Section II is for the UMass Lowell employee to complete. Next, the employee should present this form, their signed medical release authorization, and their job description to their health care provider.***
- ***Section III is to be completed by the employee's health care provider. The form should then be returned to EEO.***

***After reviewing this request, EEO may contact the health care provider for additional information if further clarification is needed. The medical information obtained in response to this request for accommodation will be maintained by EEO in a file separate from the employee's 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 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 or family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R 1635.8(b)(1)(B)***

**I. EMPLOYER INFORMATION:**

**Name:** UNIVERSITY OF MASSACHUSETTS LOWELL, Equal Opportunity & Outreach

**Address:** Wannalancit Mills Suite #354, 600 Suffolk Street, Lowell, MA 01854

**Phone:** (978) 934-3565 Fax: (978) 934-3032

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

1. Full Name: \_\_\_\_\_  
  First  Middle  Last

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

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

\_\_\_\_\_

3. If you have received treatment for this from other providers, please indicate from whom:

\_\_\_\_\_

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

Note: *If in the event of an emergency you may require assistance, please ask your health care provider to complete the item beginning "If applicable" at the end of Section III below. Your signature below authorizes EEO to disclose relevant confidential information about your medical condition to first aid or safety personnel. Please contact EEO if you have any questions or concerns.*

4. Employee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**III. TO BE COMPLETED BY HEALTH CARE PROVIDER:**

Your patient/client identified above is an employee of University of Massachusetts Lowell, and has requested a workplace accommodation under the Americans with Disabilities Act Amended 2008. They have signed the attached Medical Authorization Release Form authorizing the disclosure of Their medical information in connection with this request for accommodation. Your input is requested below in order that we may evaluate their request for accommodation taking into account your professional opinion. **Please refer only to those impairments for which your client/patient is requesting accommodation (see Section II, item 2 above).** After reviewing your input, EOO or your client/patient may contact you for additional information.

- 1. Name of health care provider completing this form: \_\_\_\_\_  
License No.: \_\_\_\_\_ Specialty: \_\_\_\_\_
- 2. Mailing Address and Telephone Number: \_\_\_\_\_  
\_\_\_\_\_

3. Please complete only the checked items below, OR initial this statement if it applies.

\_\_\_\_\_ **(If applicable: Initials) I do not have sufficient information regarding this patient/client to complete the checked items below. (If you initialed here, skip to item 4.)**

**DURATION OF IMPAIRMENT(S)**

What is the date the impairment commenced for which your patient/client is requesting an accommodation (in Section II.2)? What is the estimated duration of the impairment? \_\_\_\_\_

**NATURE OF IMPAIRMENT(S)** Please refer to the attached job description.

Please indicate the major life functions in which your client/patient has impairments which may limit his/her ability to perform the functions of his/her position 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; or the operation of a major bodily function.

\_\_\_\_\_  
\_\_\_\_\_

**FUNCTIONAL LIMITATIONS** - Please refer to the attached job description.

Please specify the aspects of the position's functions in which your client/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 amounts of weight, time, distance, repetition, etc. to which your patient/client is limited without accommodation, or specify environmental factors which limit his/her ability to perform his/her duties. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**INPUT ON ACCOMMODATIONS** - Please refer to the attached job description.

Please describe what in your opinion constitutes the appropriate type or nature of accommodation(s) which would enable your patient/client to fully perform his/her job duties. Please do not refer to specific rooms or work areas.

\_\_\_\_\_  
\_\_\_\_\_

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(section III continues on page 3)

**III. (CONTINUED)**

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If applicable, please describe what assistance your patient/client requires in the event of an emergency. For example, what are the appropriate actions if the client/patient's assistive technology fails to operate properly or if an elevator is temporarily out of service?

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*If desired, please feel free to provide additional information on letterhead signed by you.*

4. Signature of health care provider completing this form:

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

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

*Please return this form to UMass Lowell, Equal Opportunity & Outreach, at the address listed in Section I.*

***Thank you for participating in this process.***