UNIVERSITY OF CENTRAL FLORIDA

Office of Institutional Equity

Reasonable Accommodation Request Form

Requestor Information

ID: _____ Request Date: _____

Name: _____

Last *First* *Middle Initial*

UCF Affiliation: _____

☐ Faculty ☐ Staff ☐ Applicant ☐ Other _____

Primary Telephone: _____ Alternate Telephone: _____

Email: _____ Activity/Job Title: _____

College/Division: _____ Department: _____

Coordinator/Supervisor: _____

Campus Location/Address: _____

The Genetic Information Nondiscrimination Act of 2009 (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 individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Identify the physical and/or non-physical impairment(s) for which you are requesting accommodation and the expected duration of the impairment(s). Include the date of diagnosis.

2. Explain how the impairment(s) listed above affect(s) your ability to perform the essential functions of your your position or to enjoy equal benefits/privileges of employment. If you are a new employee, state anticipated difficulties you foresee in completing your job duties, or enjoying equal benefits/privileges of employment. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

3. List the accommodation(s) you are requesting in order to perform your essential job functions, or to enjoy equal benefits/privileges of employment. (Non-faculty employees: please attach your position description to the Provider Certification of Disability Form.)

If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? ☐ Yes ☐ No

If yes, please explain:

Is your accommodation time sensitive? ☐ Yes ☐ No

If yes, please explain:

4. Please provide any additional information that may be helpful in processing your request.

5. Medical verification of the impairment(s) (check the appropriate box(es)):

☐ I have enclosed the applicable medical documents with this request.

☐ I have NOT enclosed the applicable medical documents with this request. Explain below.

☐ ** I believe that I have already provided sufficient medical information to:

Name	UCF Job Title	Contact Information

☐ The disability and need for a reasonable accommodation is obvious and no medical documentation is needed. Explain below.

**For example, if you have requested FMLA leave for the same impairment(s), the Certification of Health Care Provider form for employees of serious health conditions may suffice.

Release of Information: I hereby certify that all statements made above are true and accurate to the best of my knowledge and belief. I hereby authorize the release of the above information to the University of Central Florida for the purpose of determining if I am a qualified individual with a disability and the appropriateness of the requested reasonable accommodation(s). I understand that it will be my responsibility to complete a Medical Release Statement and to furnish a Provider Certification of Disability, if required, to the UCF OIE for my request to be evaluated. Provider Certification of Disability can be fulfilled through existing medical documentation or the UCF Reasonable Accommodation Medical Certification form. I further authorize the University of Central Florida to seek clarification of this document and the Provider Certification of Disability, if necessary, by contacting my physician(s) or healthcare provider(s).

Requestor's Signature	Date

** **Please return this completed form to:**

Office of Institutional Equity
University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81) Orlando,
Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu

UNIVERSITY OF CENTRAL FLORIDA

Office of Institutional Equity

Medical Information Request Form – Healthcare Provider

Medical Release (Completed by the Requestor)

Name: _____

Last *First* *Middle Initial*

Employee ID: _____

UCF Affiliation: _____

☐ Faculty ☐ Staff ☐ Applicant ☐ Other _____

Primary Telephone: _____ Alternate Telephone: _____

Email: _____ Activity/Job Title: _____

Name of Healthcare Provider: _____

Healthcare Provider's Phone: _____

I, _____, hereby authorize the above-named healthcare provider to complete this form and disclose to the University of Central Florida and its authorized representatives the following information related to my healthcare: the diagnosis(es) of relevant conditions, treatment plan(s), my ability to perform my work, recommendations, history, reports and correspondence.

I understand that it may be necessary for the University representatives to share this information for purposes related to accommodation of a disability. I authorize the University to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process.

This authorization is valid for the duration of the Office of Institutional Equity's accommodation request process. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named healthcare provider will not condition treatment or payment based on receipt of this signed authorization.

_____ _____

Requestor's Signature Date

DO NOT RETURN THIS FORM TO YOUR DEPARTMENT

** **Please return all completed health care provider portions of this form to:**

Office of Institutional Equity University of Central Florida
12701 Scholarship Drive, Suite 101 (Building 81)
Orlando, Florida 32816-0030
Fax: (407) 882-9009 or Email: oie@ucf.edu