University of Houston
Medical Inquiry Form

Employee Name: ____________________________________________________________________________________

Department/Title: _____________________________________________________________________________________

The above employee has requested an accommodation based on a medical condition. Attached is a copy of the employee’s job description. Please review the highlighted essential job functions. In answering the following questions, address any limitation(s)/restriction(s), if any, that may exist in the employee’s performance of those job functions due to his/her medical condition. If you identify any limitation(s)/restriction(s), please provide suggestions for possible accommodations you believe may allow the employee to perform his/her essential job functions. Attach a separate sheet, if necessary. (NOTE: Please attempt to use the same language contained in the job description when addressing specific limitations.)

When answering the first three questions, please do not take into consideration any remedial effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

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 family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. (75 Fed. Reg. 68934)

Please contact the University of Houston’s Office of Affirmative Action/Equal Employment Opportunity at (713) 743-8835 if you have any questions about completing this form. Your assistance is greatly appreciated!
1. Does the employee have a physical or mental impairment?
   
   Yes □    No □

   What is the impairment? ________________________________________________________________

2. Is the impairment:    Short Term □  Long Term □  Permanent □

   If not permanent, how long will the impairment likely last? ______________________________________

3. Does the employee’s impairment substantially limit any major life activities?

   Yes □    No □

   If so which major life activities are limited?

   ______________________________________________________________________________________

4. After reviewing the employee’s job description, can the employee perform all of his/her essential job functions?

   Yes □    No □

   If not, which of the essential functions of his/her job can he/she not perform?

   ______________________________________________________________________________________

   ______________________________________________________________________________________

5. List suggestions, if any, you may have regarding possible accommodations to allow the employee to perform his/her essential job functions.

   ______________________________________________________________________________________

   ______________________________________________________________________________________

   ______________________________________________________________________________________

   ______________________________________________________________________________________

   ______________________________________________________________________________________

   __________________________________________  __________________________________________

   LICENSED HEALTH CARE PRACTITIONER / DATE          PRINTED NAME
University of Houston
Request for Workplace Accommodation Form

Employee Requesting Accommodation _________________________       Date ___________________
Job Title____________________ Department __________ ____________     Ext.______________

_____________________________________________________________________________________

Type of Accommodation Requested
___ schedule change    ___ work site modification  ___ modification of duties
___ special equipment needed  ___ job restructuring   ___ interpreter/reader
___ modification of equipment  ___ other ___________________________________________________

Employee must provide a detailed description of each type of requested accommodation in the space below (attach a separate sheet, if necessary):

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_____________________________________________________________________________________________

Medical documentation to support accommodation request attached:   Yes ☐     No ☐

I authorize the Office of Affirmative Action/Equal Employment Opportunity (“OAA/EEO”) to contact and exchange information with my supervisor, my licensed health care practitioner and/or any other individual the OAA/EEO deems appropriate, pertaining to my ability to perform my essential job functions, to work in the job environment, and to work a particular job schedule. Information exchanged will be limited to those individuals responsible to make and/or implement workplace accommodation determinations.

Employee Signature _____________________________________  Date ____________________

_____________________________________________________________________________________________

FINAL APPROVAL IS SUBJECT TO INSTITUTIONAL REVIEW

Original:  ADA Coordinator    Copy: Employee’s Supervisor
OAA/EEO 3020
(713) 743-8835
The employee’s request for an accommodation, and all supporting documentation, has been thoroughly reviewed by the ADA Coordinator, the requesting employee’s supervisor, and the employee. Based on that review, the request for accommodation has been:

- **APPROVED**
- **APPROVED IN PART**
- **DENIED, ALTERNATIVE WORKPLACE ACCOMMODATION OFFERED**
- **DENIED**

If approved, approved in part or an alternative workplace accommodation offered, the accommodation will consist of the following (attach an additional sheet, if necessary):

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

The requesting employee has been informed by the ADA Coordinator that the employee’s job will be performed within the following medical restrictions, if any:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

The requesting employee has been informed that, due to possible future business necessity, the essential functions of the employee’s position may change necessitating a re-evaluation of an accommodation.

The requesting employee has been informed that a change in the employee’s medical condition may necessitate re-evaluation of an accommodation.

The requesting employee has been informed that he/she is subject to all University of Houston rules, regulations, and policies applicable to employment.

Employee Signature _____________________________  Date _________________________

Department Signature ____________________________ Date _________________________

ADA Coordinator/Rep. ____________________________ Date _________________________