University of Wisconsin-Stevens Point
REQUEST FOR REASONABLE ACCOMMODATION

RELEASE OF INFORMATION FORM

The employee referenced below has requested an accommodation for a disability. A copy of this employee's position description is attached for your review prior to your completion of the questionnaire. Please return this form as soon as possible to Mai H. Vang, Equity and Affirmative Action; University of Wisconsin- Stevens Point, 210B Main; 2100 Main St., Stevens Point, WI 54481 (phone #: 715.346.2158). Upon receipt of this form, the University may follow-up with questions relating to the requested accommodation.

RELEASE OF INFORMATION

Employee Name:______________________________________

Job Title: ____

I hereby authorize a reciprocal exchange between my health care provider(s) ___________________ and the Equity and Affirmative Action Office including all personnel and medical records, concerning my ability to perform job-related functions with or without reasonable accommodation. I authorize the Affirmative Action Officer (or designee) to speak directly to my health care provider(s). I further authorize my health care provider(s) to provide professional opinions regarding these records and regarding my ability to perform job-related functions. I understand that this exchange of information is necessary for the University to respond to my request for a disability accommodation. I further understand that by signing this Release, I am authorizing my health care provider(s) and the University to access information that might not otherwise be available to them. This authorization is valid for one year from the date of my signature below. A photocopy of this authorization may be used in the same manner and with the same effect as the original document.

Employee Signature:____________________________________

Date:________________

Definitions

A disability is a physical or mental impairment that substantially limits one or more major life activities. Major life activities include caring for oneself, walking, sitting, standing, lifting, seeing, breathing, learning and working. Mitigating factors, such as the effects of medication, must be considered when determining if an individual is disabled.

An accommodation is a modification to the position that enables an employee to perform the essential functions of the position.

HEAL TH CARE PROVIDER QUESTIONNAIRE

The University is seeking detailed information regarding this employee's functional capabilities. Please carefully review this employee's job description and respond to the following questions. If you have questions regarding the employee's job responsibilities, please call the Affirmative Action/Equal Employment Opportunity Officer. (Please use additional page if necessary)

1. What is the nature of the condition that impacts this employee's ability to perform the employee's essential job functions as described in the job description?

2. Please explain, how, in your opinion, this condition does or does not meet the definition of a disability under the ADA.

3. Which major life activities are affected by this condition and how are they affected?

4. How long is the condition expected to last?

5. Based on the employee's job description, what specific job functions do you believe the employee would <u>not</u> be able to perform without an accommodation? Explain the basis for this belief.

6. What accommodation do you believe would allow this employee to perform all of the essential functions of the employee's job? Are there alternative accommodations?

Name of employee: ____

Name of Health Care Provider: State License #:____

Address: ____

Title/Degree: ____

Telephone #: ____

Health Care Provider's Signature:____

Date:_____________________________