

UIC Employee Request For Reasonable Accommodation Based on Medical Condition

By considering this request or granting an accommodation, UIC is not considering or regarding the employee as having a disability as defined by the Americans with Disabilities Act, the ADA Amendments Act of 2008, or a handicap as defined by the Illinois Human Rights Act. For the UIC Employment Accommodation Policy see: <http://www.oae.uic.edu/docs/accomempol.doc>

SECTION I : EMPLOYEE'S INFORMATION AND REQUEST **(To Be Completed By Employee)**

First Name		Last Name		Phone Number	
Email			Job Title / Classification		
Street Address					
City			Zip Code		
College/ Department/ Unit			Status (Select One: AP, Extra Help, Faculty, Support Staff)		
Supervisor's First Name		Supervisor 's Last Name		Supervisor's Phone Number	
Supervisor's Email					

1. Describe how your (Employee's) condition prevents you (him/her) from performing assigned job duties: (attach additional pages if necessary) (DO NOT DISCLOSE YOUR MEDICAL CONDITION ON THIS FORM. ALL MEDICAL DOCUMENTATION AND A DESCRIPTION OF YOUR MEDICAL CONDITION SHOULD BE PROVIDED TO UNIVERSITY HEALTH SERVICES ONLY.)

2. Describe the specific reasonable accommodation that you (Employee) are requesting:

3. Verification of medical condition. (Check the box that is most applicable).

- I believe my medical condition is observable and has an apparent relation to the accommodation requested.
(If the above statement is not applicable, or the relationship between the observable medical condition and accommodation requested is not clear, the employee must verify his/her condition at University Health Services or, if employee is located at a satellite location, then at an otherwise designated location).
- My medical condition has been verified prior to this request by University Health Services.
- I understand that I will need to verify my medical condition with University Health Services. (*Submit completed form to UHS*).

Employee Signature	Date
Signed By	

Section II: Verification of Medical Condition (To Be Completed by University Health Services)

Note to Employee: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting 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.

- Employee's documentation requires that an accommodation be considered.
- Employee's documentation supports an accommodation only on a discretionary basis.
- Employee's documentation does not support request for accommodation.
- Independent evaluation recommended with report to be submitted to UHS.

Type of Disability: (Select One: ADHD | Blind/Low Vision | Chemical Sensitivity | Deaf/Hard of Hearing | Developmental | Health Problems | Learning | Mobility | Physical | Psychological | Systemic/Chronic | Other: (Please Specify))

UHS Reviewer's First Name	UHS Reviewer's Last Name	Phone Number	Email
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UHS Reviewer's Signature	Date
Signed By	

SECTION III: COLLEGE/UNIT/DEPARTMENT PRELIMINARY DECISION (To Be Completed By Employee's Supervisor or Human Resources Representative)

First Name	Last Name	Phone Number	Email
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1. Provide a brief description of the responsibilities and methods essential to satisfactory performance of this employee's job. (Attach a job description if available).

I have attached a job description.

2. Preliminary Decision: (check the box)

- Approved
- Modified
- Denied

(Note: Before a requested accommodation can be denied, a reviewer must engage in the interactive process with the employee and the Office for Access and Equity.)

3. Description of the reasonable accommodation approved:

Supervisor/ Human Resources Representative Signature

Date

Signed By

Submit completed form to, the Office for Access and Equity, 717 Marshfield Building (M/C 602), Facsimile: 312-413-0055.

SECTION IV: FINAL DECISION

(To Be Completed By the Office for Access and Equity)

1. Request is:

- Approved
- Modified
- Denied

2. Description of the reasonable accommodation approved or reason(s) for denial:

OAE Representative Signature

Date

Signed By