



**MEDICAL PROVIDER INFO IN RESPONSE TO AN EMPLOYEE'S ACCOMMODATION REQUEST AMERICANS WITH DISABILITIES ACT, AS AMENDED (ADAAA)**

Instructions to Physician: A request for an accommodation has been made by our employee/your patient ("Employee"). Please answer each question below. All the following information is needed so that TAMU-CC may assess its obligations under the law and assist the University in satisfying its obligations to engage in an interactive process and dialogue with \_\_\_\_\_ (Employee). Please review the attached job description prior to completing this form.

*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 the individual's family medical history, the results of the individual's genetic tests, the fact that the individual sought or received genetic services, and genetic information of a fetus carried by the individual or an embryo lawfully held by the individual receiving assistive reproductive services.*

**Important Note: Please -- DO NOT volunteer any diagnosis information. To assess our obligations, we only need information that pertains to whether or not the individual is capable of performing the essential functions of his job, either with or without reasonable accommodation.**

Name of Employee/Patient: \_\_\_\_\_

Name/Title of Medical Provider completing this form: \_\_\_\_\_

1. Is the Employee currently restricted in his ability to perform any of the functions of the position? Please refer to the attached job description to make your assessment.

Yes \_\_\_ No \_\_\_

If so, please identify any functions \_\_\_\_\_ (Employee) is not able to perform and describe any restrictions in detail:

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

2. Are these restrictions temporary \_\_\_ or permanent \_\_\_?

If temporary, when will the restrictions end, or when do you predict they will end?

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

3. Are there accommodations that might help \_\_\_\_\_ (Employee) perform the functions of the job?

Yes \_\_\_ No \_\_\_



If yes, please describe any suggested accommodations in detail and explain why you believe these will help (Employee) perform his/her job functions as identified in the job description, and for how long each of the accommodation(s) would be needed:

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4. Do you believe, based on your discussions with the employee and/or your assessment of the employee’s medical condition, either (1) that another medical provider should also provide information in response to any or all the questions in this Questionnaire, or (2) that another medical provider would be in a better position than you to address these questions?

Yes \_\_\_ No \_\_\_

If yes, please identify the medical provider(s) (by name and specialty) and explain why:

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**CERTIFICATION**

By signing below, I certify that the answers provided in response to the above questions are based on my own personal knowledge of the relevant medical facts from my own examination of the Employee or based on my own review of the relevant medical documentation, and my answers represent my professional medical opinion.

Health Care Provider’s Name (Please Print) \_\_\_\_\_

Health Care Provider’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider’s Specialty or Type of Practice: \_\_\_\_\_

Provider’s Telephone and Fax Number: \_\_\_\_\_

**Please return this form to:**

Rosie Ruiz, Ed. D.  
Texas A&M University-Corpus Christi  
PHR, CAAP, SHRM-CP,  
Associate Director, Employee Development & Compliance Services  
Title IX & ADA Coordinator  
Employee Relations, Equal Opportunity  
361-825-5826  
<https://edcs.tamucc.edu>  
[rosie.ruiz@tamucc.edu](mailto:rosie.ruiz@tamucc.edu)