UNIVERSITIES OF WISCONSIN

# Disability Accommodation Health Care Provider Form

**Employee Name:**

**Position/Job Title:**

**Phone Number:**

**Current Remote/Telecommuting Status:**

Dear Health Care Provider:

The individual listed above has requested accommodations with Universities of Wisconsin. In order to fulfill our responsibilities under the American with Disabilities Act (ADA), corresponding laws and internal policies, we are requesting information about your patient's medical conditions. Please answer the following questions utilizing the employee's position description which is included:

1. Does the individual have an impairment or impairments that substantially limits one or more major life activities? Major life activities are defined as those that an average person can perform with little or no difficulty, such as caring for oneself, walking, seeing, hearing, breathing, learning, sitting, concentrating, interacting with others, sleeping, etc.

   **Yes** ☐
   **No** ☐

2. If yes, please indicate which conditions would be considered as meeting the impairment standards and how those impairments substantially limit one or more major life activities? Please be as specific as possible.

3. Describe the **nature** (temporary, chronic, permanent, etc.) and **severity** (mild, moderate, severe, etc.) of the impairments. For temporary impairments, please indicate what factors may influence the nature of impairments going forward (i.e., upcoming treatments, evaluations, procedures, medication changes, etc.).

4. Your patient has requested the accommodations found in the accompanying paperwork. Taking this information into account, please answer the following questions:
    a. Are these accommodations appropriate in relation to the nature of the impairments and the required job duties? If yes, how will each requested accommodation assist the employee in successfully completing the essential functions of their position?

    b. Will alternative accommodations, other than what was requested by your patient, address the limitations equally as effective? If yes, please indicate what those alternative accommodations may be.

    c. How long will these accommodations be necessary?

**Please sign and date to indicate your agreement with the above medical information.**

Signature of Medical Treatment Provider:

Date:

Title:

Health Care Provider:

Phone Number:

Fax Number:

Address:

**Please return form to:**

[Insert ADA Coordinator Name]
[Insert ADA Coordinator Address]
[Insert city, state, zip]
[Insert email]
[Insert ADA Coordinator Fax]