Broward Health

Employee Request for Reasonable Accommodation Form
(For Physical or Mental Impairments)

Employee Name: _____ **Employee ID:** _____ **Date**: _____

Location: _____

Position/Title: _____

Personal (Not Work) Email: _____

Primary Telephone Number: _____

Supervisor Name/Department Head: _____

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 specifical y 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 Responsibility: Once you have completed this form, please return it to GML@browardhealth.org. This form Will be kept separate from your personnel file and as a confidential medical record. Medical information will be kept confidential and not disclosed except to your employer's Human Resources Department personnel as needed to determine reasonable accommodation and. otherwise, as required or permitted by law.

Limitations

Please describe the nature, extent, and duration of your condition§§, and how those limitations are specifically preventing or negatively impacting your ability to perform the essential functions of your job.

Medical Professional Name:_____

Medical Professional Phone:_____

Medical Professional Fax: _____

Medical Professional Address: _____

By signing below, I attest that the information I have provided on this form is true and correct to the best of my knowledge. I understand and agree that my failure to timely provide accurate information may constitute grounds for denial of my request for accommodation and/or discipline.

Signature_____Date_____

By signing below, I separately authorize my employer to verify any and all information with my medical professional identified above and/or obtain clarification in connection with my request in accordance with applicable law.

Signature_____Date_____

MEDICAL CERTIFICATION FORM IN RESPONSE TO AN ACCOMMODATION REQUEST
(**TO BE COMPLETED, IN ENTIRETY, BY THE HEALTHCARE PROVIDER**)

Employee Name: _____ **DOB**: _____

A. QUESTIONS TO DETERMINE WHETHER AN EMPLOYEE HAS A QUALIFYING DISABILITY:

1. Does the employee have a physical or mental impairment that:

   a. Substantially limits a major life activity? ☐ Yes ☐ No

   b. Relates to pregnancy, childbirth, or a related medical condition? ☐ Yes ☐ No

   If yes to either or both of the questions above, please describe the nature of the impairment:
   _____
   _____
   _____
   _____.

2. Nature of impairment: ☐ Permanent ☐ Temporary

3. Does the employee's impairment described above prevent the employee from performing one or more essential job functions?

   ☐ Yes ☐ No

   If yes, please indicate in the chart below those areas in which the employee has limitations and the nature of any identified limitation with as much specificity as possible. If, for example, the employee needs to take breaks, please specify the length of such breaks in minutes and the frequency in which such breaks should be taken. If the employee has lifting or push/pull restrictions, please specify the nature of sure restrictions in pounds.

Task	Yes	No	Nature of limitation
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Reaching Overhead			
Kneeling			
Pushing & Pulling			
Crouching/stooping			
Lifting			
Use of hands/Motor Skills			
Other (be specific)			

4. Is the employee taking medication related to the employee's physical or mental condition at issue that could impair or interfere with the employee's ability to perform job functions?

   □ Yes □ No

   If yes, please explain how the medication impairs/interferes with the employee's ability to perform his/her essential job functions (including side effects of medication): _____
   _____
   _____
   _____
   _____.

B. <u>QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTION(S):</u>

1. An accommodation is one or more modifications or adjustments to the work environment, or to the manner or circumstances under which the position held is customarily performed. Please identify any possible accommodations, specifying how the accommodation(s) identified would enable the employee to perform his/her essential job duties? _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____.

2. How long do you anticipate the employee will need the accommodation(s) identified above?

   Start Date: _____ End Date: _____

   If the identified need for accommodation is for an indefinite or unknown duration, please specify here:
   _____
   _____.

3. For Leaves of Absences (<u>complete only if leave is the suggested accommodation</u>):

   a. IF CONTINUOUS, how long do you anticipate the employee will need continuous time off from work based on your medical knowledge and expertise?

      Start Date: _____ End Date: _____

   b. IF INTERMITTENT, please specify the duration as well as the frequency of the need for leave and duration of the related incapacity per episode. (Ex. 1 episode every 3 months lasting 1-2 days)

      Start Date: _____ End Date: _____

      Frequency: _____ (times) per _____week/s or _____month/s

      Duration in hour(s): _____ or in day(s) per episode: _____

C. MEDICAL CERTIFICATION:

By signing below, I attest and hereby certify that the information I have provided on pages 1-2 of this form is true and correct to the best of my knowledge. I have completed this form in my capacity as the employee's treating healthcare provider.

Medical Professional's Signature: _____ *Date:* _____

Print Name: _____ *Specialty:* _____

Phone: _____ *Fax:* _____

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Please return to the Leave Admin Center by FAX to: 954-888-3477