

**Medical Information Request Form**

Date: \_\_\_\_\_

Name of Employee: \_\_\_\_\_

Name and Title of Person Completing this Form: \_\_\_\_\_

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Does the employee currently have a physical or mental impairment? Yes No

If yes, what is the nature and severity of the impairment?

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What is your prognosis as to the duration of her/his condition?

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Does the impairment substantially limit a major life activity? Yes No

If yes, what major life activity(s) is/are limited? \_\_\_\_\_

*(examples: speaking, hearing, seeing, breathing, walking, standing, sitting, sleeping, reaching, learning, concentrating, thinking, reproducing, caring for self, interacting with others, performing manual tasks)*

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Does the impairment substantially limit a major bodily function? Yes No

If yes, what major bodily function(s) is/are limited? \_\_\_\_\_

*(examples: circulatory, endocrine, reproduction, hemic, special sense organs and skin, lymphatic, immune, normal cell growth, digestive, neurological, brain, respiratory, bowel, bladder, genitourinary, musculoskeletal, cardiovascular)*

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What are the limitations/restrictions caused by the condition and/or the treatment of the condition?

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(Over)

Please indicate how the condition impacts his/her ability to perform the essential job functions, and how long you anticipate the condition will last.

<u>Essential Job Function</u>	<u>Limitation/Impact</u>	<u>Anticipated Duration</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

What accommodation, if any, do you believe will enable the employee to perform the essential job functions?



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Signature of Medical Professional

Date

***Please return to:***

***For Medical Center Employees –***

*Rebecca Schmale, Medical Center Employee Relations, Box 800567, Charlottesville, VA 22908-0567*

***For University Academic Employees –***

*Angelee Godbold, University Human Resources, Box 400127, Charlottesville, VA 22904-4127*

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