UNLV Office of Equal Employment and Title IX
ADA Accommodation Applicant
Health Care Provider - Medical Verification Form

Americans with Disabilities Act (ADA) Accommodation - Accommodation Request Medical Provider's Form:

Title 4, Chapter 8, Section 14 of the Nevada System of Higher Education (NSHE) Handbook provides that NSHE is committed to compliance with any and all federal and state laws governing individuals with disabilities and their employment. This includes the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973.

That provision further provides in pertinent part that pursuant to federal and state laws, no qualified individual with a disability shall unlawfully be denied access to or participation in any services, programs, or activities of NSHE or its institutions on the basis of his or her disability. NSHE and its institutions are committed to providing reasonable accommodations to among other things, employees with disabilities to afford an opportunity for full participation in educational programs and activities.

The provision defines a "Reasonable Accommodation" among other things as an adjustment or modification that allows the qualified individual with a disability access to employment. A reasonable accommodation under this provision shall not, among other things, fundamentally alter the essential functions of any job, nor shall it impose an undue burden, on NSHE, any NSHE institution, or any program or activity thereof.

That provision provides further that every qualified individual with a disability has the responsibility to, among other things: Provide documentation from a professional with appropriate credentials for diagnosing that disability verifying the nature of the disability, functional limitations, and the rationale for specific accommodations being requested.

Pursuant to these provisions, as an applicant for an accommodation under the ADA, the Office of Equal Employment and Title IX requires that you have the medical provider you are relying upon to support your request for an accommodation complete and sign the following accommodation questionnaire to enable the Office of Equal Employment and Title IX to work with your department and determine the necessary and appropriate accommodations.

Please provide this document to your healthcare provider and have them answer each question beginning on the next page as complete as possible based upon the information known to date and then sign the document. *Note, you may need to provide your job description or Position Description Questionnaire ("PDQ") to your healthcare provider and/or have a discussion with your healthcare provider of what your job functions entail for them to be able to answer all the questions below. The Office of Equal Employment and Title IX Analyst assigned to your matter can help obtain your job description or PDQ and provide that to you.*

See Next Page.

UNLV Office of Equal Employment and Title IX
ADA Accommodation Applicant
Health Care Provider - Medical Verification Form

UNLV Employee Name: ____

For Health Care Provider Completion Only:

1. Health Care Provider Information:

Printed Name:____

Medical Areas of Expertise: ____

Work Address and Phone
Number:____

____

Preferred Email Address I Can Be Contacted At: ___________________________________

I am the medical provider that diagnosed the patient's condition set forth below YES/NO (circle one)

Length Of Time Patient Has Been In My Care____________________________________

2. Please identify and describe the medical impairment(s) or condition your patient has, which may qualify as a "Disability" under the ADA, for which your patient is seeking an accommodation:

3. Please describe the severity and duration of the impairment/condition discussed above:

4. Please describe the limitations your patient has because of the impairments/conditions identified above.

5. Please have a discussion with your patient about their job functions and review any job description and/or Position Description Questionnaire ("PDQ") your patient has to provide. Describe the job function(s) and/or job facilities your patient is having trouble performing or accessing because of the limitations discussed above.

6. Please provide a recommendation of one or more reasonable accommodations that will enable your patient to perform the essential functions of their position. **See #9 below for leave accommodations.**

7. Please estimate but provide as specific as possible at least how long the accommodations will be necessary (you may provide that the accommodations will be necessary at least until a specific date, subject to improvements in the patient's condition and future appointments that you have with them).

❏ The Accommodations will be necessary at least until the following date ______________

8. Please discuss how that recommended accommodation(s) will allow your patient to perform the essential functions of their position.

9. Leave Accommodations (complete if applicable):

___________ Provide “yes” here if your recommended accommodation is leave because your patient is presently unable to perform their job.

Provide the minimum length of time your patient will need to be on leave because they are unable to perform the functions of their job. If possible, please estimate a date that your patient will be able to return to work.

Length of Time on Leave:____

Date of Estimated Return to Work:____

- If the return to work will be known after a follow up appointment with your patient occurs, please state when that follow up appointment will be below:

Follow Up Appointment Date:____

a. If known now and not otherwise addressed above, please estimate what restrictions or job modifications will be necessary when your patient is approved to return to work (Note, this information can be provided if applicable at a date closer to the patient’s return to work):

____ ____________________

Signature Required - Health Care Provider’s Signature Date

UNLV Office of Equal Employment and Title IX
ADA Accommodation Applicant
Health Care Provider - Medical Verification Form

MEDICAL/HEALTHCARE INFORMATION RELEASE FORM

This form will not be placed in your employment record file. Medical Information Request and Verification for Employee Requesting Accommodation under the Americans with Disabilities Act. Submit a Medical / Healthcare Information Release Form for EACH health care provider you authorize to release information.

Patient Name: ______________________________

Date of Birth: ______________________________

Medical ID/Patient Number, or Last 4 digits of Social Security: ______________________________

Name and Title of Health Care Provider: ______________________________

Name of Facility: ______________________________

Telephone Number: ______________________________

Fax Number: ______________________________

Address of Facility: ______________________________

____

Brief description of disability/limitation for which you are requesting accommodation: ______________________________

I do hereby authorized the University of Nevada, Las Vegas EEO/AA Compliance Officer to communicate verbally and in writing, if, necessary, with the appropriate health care or rehabilitation professionals with regard to the resolution of my request for a disability accommodation. My signature indicates that I am aware of the nature of the information being disclosed and with whom it will be shared. A complete photocopy of this authorization shall be accepted as if it were a signed original and is valid from the date of this release until the University completes its evaluation of my request for accommodation of this condition. I release the above named Physician/Medical Professional from any liability associated with the disclosure of confidential or privileged medical/healthcare information. I understand that the University of Nevada, Las Vegas EEO/AA Compliance Officer cannot properly evaluate my request for accommodations unless I sign this release and that any information disclosed under this release could potentially be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that I may revoke this release in writing at any time by sending a written revocation of authorization to: EEO/AA Compliance Officer UNLV, 4505 Maryland Parkway, Box 451062, Las Vegas, NV 89154-1062, 702-895-4055.

____

Employee Signature Date