

Employee Accommodation Request: Medical Information Form



Office of Equity and Inclusion
Phone: (937) 775-3207
Fax: (937) 775-3027
Email: oei-ada@wright.edu
Web: www.wright.edu/oei

The Office of Equity and Inclusion (OEI) at Wright State University coordinates reasonable accommodations for employees with diagnosed and qualifying disabilities in accordance with the Americans with Disabilities Act, as amended. In doing so, OEI staff enter into an interactive process in order to implement the most appropriate accommodation strategies for the workplace. As part of the interactive process, OEI seeks input from the employee's licensed medical provider. The licensed medical provider completing this form should be licensed in the field of expertise to make the diagnosis.

The Office of Equity and Inclusion will keep this information confidential and it will not be added to an individual's personnel file. The collected data will only be used in accordance with federal regulations as outlined in Title 41, Code of Federal Regulations Part 60-741.23(d). Please feel free to contact the Office of Equity and Inclusion with any questions or concerns you might have regarding the information you are being asked to provide.

Thank you in advance for your assistance.

EMPLOYEE AND MEDICAL CONDITION INFORMATION (TO BE COMPLETED BY LICENSED MEDICAL PROVIDER)

Employee's Name

Date of Last Contact with Employee

Please describe the employee's medical condition that is related to the request for an ADA accommodation.

Approximately when was the medical condition diagnosed?

How long is the medical condition expected to last?

Please describe how this medical condition may affect this employee at work, specifically how may this condition affect the employee's ability to perform the essential functions of their job. (You may ask for a job description to make this assessment.)

Please list any accommodations that you feel are reasonable and would assist this employee in performing their essential job duties. (You may ask for a job description to make this assessment.)

Please describe any specific concerns you may have or other ways that we may further assist this employee in the employment setting.

Is there any additional information OEI should be aware of when evaluating the accommodation request?

LICENSED MEDICAL PROVIDER INFORMATION (TO BE COMPLETED BY LICENSED MEDICAL PROVIDER)

Name and Title (printed)

Signature

Professional License Number

Date

Office Address

Office Phone Number

Please mail or fax this form using the contact information below. For privacy purposes, please do not email this form.

Wright State University
Office of Equity & Inclusion
3640 Colonel Glenn Highway
436 Millett Hall
Dayton, OH 45435-0001
Fax: (937) 775-3027

A copy of this employee's authorization for the release of this information to the Office of Equity and Inclusion is available upon request. Please call (937) 775-3207 or email oei-ada@wright.edu. Thank you!