

Human Resources

Reasonable Accommodation Healthcare Provider Form

Vanderbilt University Medical Center (VUMC) provides reasonable accommodation(s) to qualified employees with disabilities. VUMC complies with the Americans with Disabilities Act (ADA) and the Americans with Disabilities Act Amended (ADAAA). As part of the accommodation request process; our employee is to have their Healthcare Provider complete this Healthcare Provider Form. The following steps must occur:

- Step 1 – Employee completes Section I of this form and signs authorizing the Healthcare Provider to release information to VUMC.
- Step 2 – Employee provides this form plus their Job Description to their Health care Provider to complete
- Step 3 – Healthcare Provider completes Section II of the Reasonable Accommodation Healthcare Provider Form and returns to:

VUMC Human Resources - Employee Relations
2525 West End Ave, Suite 500
Nashville, TN 37067
Fax: (615) 343-2176

employeerelations.vumc@vumc.org

**Employees must open an accommodation request in Workday
and upload this form at: [Workday Help Center](#)**

If you have any questions about this form or the process, please reach out to Employee Relations at:
(615) 343-4759.

Section I – To be Completed by the Employee:

Employee Name: _____ Job Title: _____

Department: _____ Supervisor: _____

Date of Birth: _____

Release of Information:

I hereby authorize the release of the following information to VUMC for the purpose of determining the availability of reasonable workplace accommodations. I further authorize VUMC to seek clarification of this documentation if necessary by contacting my physician or care provider.

Employee Signature: _____ Date: _____

Section II – To be Completed by the Healthcare Provider:

To Healthcare Provider:

To initiate a request for reasonable accommodations, employees must provide current documentation of a disability. As the employee's physician or Health Care provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary. Note: Federal and state law define a disability as a physical or mental impairment that substantially limits one or more major life activities, an individual having a record of such impairment, or an individual being regarded as having such impairment.

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To complete this form, you should review the employee's job functions and other information relevant to the employee's job at VUMC. If those materials have not been provided, please contact the employee and let him or her know you cannot complete this form without those materials.

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 specifically 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.

Thank you for your assistance.

Medical Information Required:

1. Does the employee have a health condition that impacts his or her ability to perform the essential functions of the job as described in the attached job description?

Please describe the health condition:

2. How does the employee's health condition interfere with the employee's ability to perform the job function(s) as described in the attached job description?

3. Please review the employee's attached job description. Please identify any job duties the employee is precluded from performing.

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4. Does the health condition prevent the employee from attending work on a regular, full-time basis? If yes, can the employee work a reduced schedule? If so, please state the number of hours per day/per week that he or she may work. Please also indicate when the employee will be able to return to work and resume performing the essential functions of the job as described in the attached job description with or without reasonable accommodation.

5. Is the employee able to perform the essential functions of his or her job as described in the attached job description with or without a reasonable accommodation?

YES, without accommodation YES, with accommodation NO

6. If “YES, with accommodation,” please describe your recommendations for restrictions, modifications or adjustments to the employee’s job duties or work environment that may be considered by VUMC in connection with the request for reasonable accommodation, be specific:

7. Are these restrictions, modifications or adjustments to the employee’s job duties or work environment expected to be permanent? Yes: _____ No: _____

- a. If you answered “No” to the above, please provide the estimated end-date for the above restrictions, modifications or adjustments: _____.
- b. If the estimated end-date to the restrictions, modifications or adjustments is unknown, indefinite or cannot be stated with particularity, please explain why this information cannot be provided with greater specificity and when you anticipate having a more definite estimate of when the restrictions, modifications or adjustments will be removed.

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Additional Comments:

Health Care Provider Name (please print):

Name:	Specialty:
Signature:	Date:
Address:	
Telephone:	Fax:

If VUMC has any questions, please contact _____

Please note: Failure to provide detailed information and to answer all questions may result in a delay or denial of request for reasonable accommodation.