



UNIVERSITY OF CENTRAL FLORIDA

Office of Institutional Equity

PUBLIC REQUEST FOR ACCOMMODATION (In compliance with Title II (Program Accessibility Requirements) of the Americans with Disabilities Act)

Requestor Information

Date Request is Submitted: _____

Is Accommodation Time-Sensitive? Yes No

If yes, please explain: _____

Person Needing Accommodation: _____
Last First M.I.

UCF Program/Activity/Service for Which Accommodation is Requested: _____

Contact at UCF for the Program/Activity/Service: _____

Date(s) Accommodation is Requested: _____

Contact Information for Person Needing Accommodation (or for person making the request, if other than the person needing accommodation)

Name: _____

Street or P.O. Box _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ Email: _____

The Genetic Information Nondiscrimination Act of 2009 (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 individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Nature of the Disability that Necessitates Accommodation: _____

Accommodation(s) Requested (be as specific as possible; attach additional sheets if necessary): _____

RETURN THIS COMPLETED FORM TO:

University of Central Florida
Office of Institutional Equity
12701 Scholarship Drive, Suite 101, Orlando, FL 32816-0030
Tel: (407) 823.1336 Fax: (407) 882.9009

Note: If an individual has a disability that is not obvious, or when it is not readily apparent how a requested accommodation relates to an individual's impairment, it may be necessary for the University to require the individual to provide documentation from a qualified health care provider in order for the University to fully and fairly evaluate the accommodation request. These information requests will be limited to documentation that (a) establishes the existence of a disability; (b) identifies the individual's functional limitations; and (c) describes how the requested accommodation addresses those limitations. Any cost to obtain such documentation is the obligation of the person requesting the accommodation.

Certification and Release of Information

I hereby certify that all statements made above are true and accurate to the best of my knowledge and belief. I hereby authorize the release of the above information to the University of Central Florida for the purpose of determining if I am a qualified individual with a disability and the appropriateness of the requested reasonable accommodation(s). I understand that it will be my responsibility to complete a Medical Release Statement and to furnish a Provider Certification of Disability, if required, to the University of Central Florida Office of Institutional Equity for my request to be evaluated. I further authorize the University of Central Florida Office of Institutional Equity to seek clarification of this document and the Provider Certification of Disability, if necessary, by contacting my physician(s) or healthcare provider(s).

Requestor's Signature

Date

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MEDICAL INFORMATION REQUEST FORM – HEALTH CARE PROVIDER

Medical Release
(Completed by the Requestor)

Name: _____

Last

First

M.I.

Date of Birth: _____ Email: _____

Primary Telephone: _____ Alternative Telephone: _____

Name of Healthcare Provider: _____

Healthcare Provider’s Telephone: _____

Describe the UCF program/activity/service for which accommodation is requested: _____

I, _____ (print name), hereby authorize the above-named healthcare provider(s) to complete this form and disclose to the University of Central Florida and its authorized representatives the following information related to my healthcare: the diagnosis(es) of relevant conditions, limitations and restrictions related to those conditions, my ability to participate in specified programs/activities/services, recommendations, history, reports, and correspondence.

I understand that it may be necessary for the University representatives to share this information for purposes related to accommodation of a disability. I authorize the University to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process.

This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named healthcare provider will not condition treatment or payment based on receipt of this signed authorization.

Requestor’s Signature

Date

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Medical Certification
(Completed by Healthcare Provider)

To the Healthcare Provider:

Your assistance is appreciated in providing information to assist in determining reasonable accommodation for the above-named individual, who has identified himself/herself as your patient. The information you provide is critical to our ability to determine the appropriate accommodations and/or modifications, if any, for this person. Please be thorough in your evaluation as you complete the attached sections as it will help us assist your patient. **Your timely completion of this form is essential to our ability to respond to your patient's accommodation request. In addition, please do not collect and provide genetic information, including family medical history.**

Please complete all sections below. If you fax the completed form, please also send the original hard copy by mail to the address designated at the bottom of the page.

Questions to Help Determine Whether the Individual has a Disability

For a reasonable accommodation under the Americans with Disabilities Act (ADA), an individual has a disability if he or she has an impairment that substantially limits one or more major life activities or has a record of such impairment. The following questions may help determine whether an individual has a disability.

Does the individual have a physical or mental impairment that substantially limits a major life activity? Yes No

If yes, what major life activity(s) (includes major bodily functions) is/are affected?

- | | | | | |
|--|--|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Hearing | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Interacting with Others | <input type="checkbox"/> Reading | <input type="checkbox"/> Standing | |
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Learning | <input type="checkbox"/> Seeing | <input type="checkbox"/> Thinking | |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working | |

Major bodily functions:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Digestive | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Special Sense Organs & Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hemic | <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Circulatory | <input type="checkbox"/> Immune | <input type="checkbox"/> Operation of an Organ | |

Questions to Help Determine Whether an Accommodation is Needed

An individual with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability

What are the limitation(s) that interfere with the individual's ability to participate fully in the UCF program/activity/service described on the first page of this request form?

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How does the individual's limitation(s) interfere with his/her ability to participate fully in the UCF program/activity/service described on the first page of this request form?

Questions to Help Determine Effective Accommodation Options

If an individual needs an accommodation because of a disability, the University must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations.

Do you have any suggestions regarding possible accommodations to assist with full participation? Yes No

If yes, what are those suggestions?

How would your suggestions improve the individual's ability to participate fully in the program/activity/service described on the first page of this form?

Comments or Additional Information in Support of Request

Signature of Healthcare Provider

Thank you for your assistance in providing this information so that we may assess the requestor/patient's request. If you have any questions about this form, please contact the Office of Institutional Equity at (407) 823-1336 or OIE@ucf.edu.

Healthcare Provider Name (please print or type)

Provider's Degree/Specialty: Please indicate any board certifications

License No.

Address

(Street)

City

State

ZIP

Phone No.

Fax No.

Healthcare Provider's Signature

Date

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