Office of Affirmative Action and Equal Opportunity Programs
3451 Walnut Street, Suite #421
The Franklin Building
Philadelphia, PA 19104-6205

REASONABLE ACCOMMODATION MEDICAL AUTHORIZATION FORM

To Penn Employee:

To initiate a request for a reasonable accommodation, an employee must:

- Submit the completed Reasonable Accommodation Request form and the Medical Information Request form to the Office of Affirmative Action/Equal Opportunity Programs Office.
- The Medical Information Request form is to be completed by the employee's physician or care provider. Employees are to complete Section I below, provide a copy of their job description to their medical provider and have the medical provider complete Section II. All documents, including the employee's job description, must be attached to this form.
- Completed forms are to be returned to: OAA/EOP, 3451 Walnut Street, Franklin Building, Suite #421, Philadelphia, PA 19104-6205 or faxed to: (215)746-7088 or by email - oaaeop@pobox.upenn.edu
  For questions, please call (215) 898-6993.
- Contents of this request are confidential and will only be shared as needed with the appropriate personnel to consider the implementation of a reasonable accommodation. All medical documentation will be kept confidential.

Section I: To be completed by employee: Penn ID:______________________

________________________________	________________________________
Employee name	Job Title
________________________________	________________________________
Department	Supervisor

Release of Information

I hereby authorize the release of the following information to Penn for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Penn 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 physician or care provider:

To Physician or Care Provider:

To initiate a request for reasonable accommodations, employees must provide current documentation of a disability or condition. As the employee's physician or 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 an impairment, or an individual being regarded as having such an impairment.

To complete this form (see attached page 2, section 2), you should review the employee's job functions and other information relevant to the employee's job at Penn. 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. Thank you for your assistance.

1. Please identify the employee's physical or mental impairment:

   ____

   ____

   ____

   - Please describe the effects or limitations (e.g. long-term, permanent, recent, short-term).

   ____

2. Please describe the effects or limitations this impairment has on the employee's activities, if any:

   ____

   ____

   ____

3. By reviewing the attached information concerning the employee's job duties, please describe the effect or limitations the impairment has on the employee's ability to perform the job duties, if any:

   ____

   ____

   ____

   - Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or other due to the impairment?

   ____

   ____

4. Please offer any suggested accommodations that might enable the employee to perform his or her job duties:

- ____
  ____________________Duration?____________________
- ____
  ____________________Duration?____________________
- ____
  ____________________Duration?____________________

Thank you for your assistance in providing this information so that we may assess the employee's request. Please sign below.

________________________________ ____________________

Signature of physician or care provider Date

________________________________ ____________________

Provider name (please print) Telephone Number