



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 Reasonable Accommodation Medical Authorization form to the Office of Affirmative Action/Equal Opportunity Programs Office. **The 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.**
- Employees are to: (1) complete Section I below, (2) provide a copy of their job description to their medical provider and (3) have their 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 via fax to: (215)746-7088 or via email to: oaaeop@pobox.upenn.edu. For questions, please call (215) 898-6993 or email oaaeop@pobox.upenn.edu.**

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

Employee Name _____

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, 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 condition or mental impairment:

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

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

3. By reviewing the information attached by the employee concerning the employee's job duties, please describe the effect or limitations the condition or 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 others due to the condition or impairment?

4. Please offer any suggested accommodations that might enable the employee to perform the employee's job duties:

- _____
_____ Duration? _____
- _____
_____ Duration? _____
- _____
_____ Duration? _____

Employee Name _____

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