

**Accommodation Certification Form**

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| **Name:** |       |

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| **A. Questions to help determine whether a person has a qualifying disability under the ADA** A person with a disability is a person with 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 this employee has a disability. |
| Does the person have a physical or mental impairment that substantially limits one or more major life activities?  |  [ ]  Yes [ ]  No |
| Does the impairment substantially limit a major life activity? |  [ ]  Yes [ ]  No |
|  If **yes**, what major life activity is substantially limited? *(Check all that apply.)* [ ]  Sitting [ ]  Standing [ ]  Walking [ ]  Lifting [ ]  Reaching [ ]  Seeing [ ]  Hearing  [ ]  Sleeping [ ]  Speaking [ ]  Breathing [ ]  Working [ ]  Thinking [ ]  Learning  [ ]  Toileting [ ]  Caring for Self [ ]  Performing manual tasks [ ]  Other:       [ ]  Operation of major bodily function (i.e. functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, reproduction)Please specify:            |
| Is the impairment permanent?  |  [ ]  Yes [ ]  No |
| If ***not*** permanent, how long, to a reasonable medical certainty, will the impairment likely last? If the impairment is episodic and/or in remission, please specify **anticipated frequency and duration of incapacity or other limitation related to the student’s academic program** (*i.e.* is this something that will cause periodic flare-ups, and if so, how often and for how long, etc.). Condition start date:            Expected length or ending date:           If episodic, Frequency:            Times per: [ ]  Week [ ]  MonthDuration:            [ ]  Hour(s) or [ ]  Day(s) per episode |

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| **B. Questions to determine specific accommodation needs**  |
| ***Student:*** Which academic-related limitations is the student experiencing as a result of his/her medical condition? |
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| **C. Questions to help determine other effective accommodation options** |
| ***Student:*** Taking into consideration the nature, severity, and duration of the student’s impairment, the limitations imposed by the impairment, and the effect of the impairment on the student’s ability to perform the essential functions of their academic program, what alterations, if any, may assist the student in obtaining effective access to his/her academic program *(e.g. time limit adjustments for substantive examinations, physical changes to the academic environment or equipment, etc.)*? Additionally, what, if any, auxiliary aids/or services may assist the student in obtaining effective access to academic programs (*e.g. screen readers, sign language interpreters, assistive devices, note-takers, etc*.)? Please include in your answer how long you anticipate these adjustments may be needed.  |
| Note: If requesting leave student should contact school’s Section 504 Coordinator. Refer to: <https://www.uth.edu/hoop/section-504-coordinators.htm>      |

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| **D. Comments** |
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**Note**: 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.

**Medical Provider Name (Print or Type):**

**Type of practice/medical specialty:**

**Address:       Telephone:**

**Medical Provider Signature:** **Date:**

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| ***For Students:*** Please return this form to your school’s Section 504 Coordinator who will coordinate with University Relations & Equal Opportunity. Refer to: <https://www.uth.edu/hoop/section-504-coordinators.htm> If you have any questions, please contact your school’s Section 504 Coordinator or University Relations & Equal Opportunity. |