OAA·EOP
University of Pennsylvania
Access • Diversity • Inclusion

Office of Affirmative Action and Equal Opportunity Programs
3600 Chestnut Street
Sansom Place East, Suite #228
Philadelphia, PA 19104-6106

REASONABLE ACCOMMODATION MEDICAL AUTHORIZATION FORM

Section I: To be completed by Employee:

In order 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 Reasonable Accommodation Medical Authorization Form is to be completed by the employee's physician or care provider. Employees are to provide a copy of their job description to their medical provider and 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, 3600 Chestnut Street, Sansom Place East, Suite #228, Philadelphia, PA 19104-6106 or faxed to: (215) 746-7088. 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.

Penn ID:_____

_____ _____
Employee name Job Title

_____ _____
Department Supervisor

Release of Information

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

_____ _____
Employee signature Date

Section II: To be completed by Employee's Physician or Care Provider:

In order to initiate a request for reasonable accommodations, employees must provide current documentation of a disability. 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.*

In order 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.

- Please identify the employee's physical or mental impairment:

_____

_____

_____

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

_____

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

_____

_____

_____

- 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?

_____

_____

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

_____

_____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