

**UNLV Office of Benefits and HR Operations  
ADA Accommodation Applicant  
Health Care Provider - Medical Verification Form**

**Americans with Disabilities Act (ADA) Accommodation - Accommodation Request  
Medical Provider's Form:**

Title 4, Chapter 8, Section 14 of the Nevada System of Higher Education (NSHE) Handbook provides that NSHE is committed to compliance with any and all federal and state laws governing individuals with disabilities and their employment. This includes the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973.

That provision further provides in pertinent part that pursuant to federal and state laws, no qualified individual with a disability shall unlawfully be denied access to or participation in any services, programs, or activities of NSHE or its institutions on the basis of his or her disability. NSHE and its institutions are committed to providing reasonable accommodations to among other things, employees with disabilities to afford an opportunity for full participation in educational programs and activities.

The provision defines a "Reasonable Accommodation" among other things as an adjustment or modification that allows the qualified individual with a disability access to employment. A reasonable accommodation under this provision shall not, among other things, fundamentally alter the essential functions of any job, nor shall it impose an undue burden, on NSHE, any NSHE institution, or any program or activity thereof.

***That provision provides further that every qualified individual with a disability has the responsibility to, among other things: Provide documentation from a professional with appropriate credentials for diagnosing that disability verifying the nature of the disability, functional limitations, and the rationale for specific accommodations being requested.***

Pursuant to these provisions, as an applicant for an accommodation under the ADA, the UNLV Office of Benefits and HR Operations requires that you have the medical provider you are relying upon to support your request for an accommodation complete and sign the following accommodation questionnaire to enable the Office of Benefits and HR Operations to work with your department and determine the necessary and appropriate accommodations.

Please provide this document to your healthcare provider and have them answer each question beginning on the next page as complete as possible based upon the information known to date and then sign the document. *Note, you may need to provide your job description or Position Description Questionnaire ("PDQ") to your healthcare provider and/or have a discussion with your healthcare provider of what your job functions entail for them to be able to answer all the questions below. The Office of Benefits and HR Operations Analyst assigned to your matter can help obtain your job description or PDQ and provide that to you.*

**See Next Page.**

**UNLV Office of Benefits and HR Operations  
ADA Accommodation Applicant  
Health Care Provider - Medical Verification Form**

UNLV Employee Name:

**For Health Care Provider Completion Only:**

1. Health Care Provider Information:

Printed Name: \_\_\_\_\_

Medical Areas of Expertise: \_\_\_\_\_

Work Address and Phone  
Number: \_\_\_\_\_  
\_\_\_\_\_

Preferred Email Address I Can Be Contacted At: \_\_\_\_\_

I am the medical provider that diagnosed the patient's condition set forth below YES/NO (circle one)

Length Of Time Patient Has Been In My Care \_\_\_\_\_

2. Please identify and describe the medical impairment(s) or condition your patient has, which may qualify as a "Disability" under the ADA, for which your patient is seeking an accommodation:

**UNLV Office of Benefits and HR Operations  
ADA Accommodation Applicant  
Health Care Provider - Medical Verification Form**

3. Please describe the severity and duration of the impairment/condition discussed above:

4. Please describe the limitations your patient has because of the impairments/conditions identified above.

**UNLV Office of Benefits and HR Operations**  
**ADA Accommodation Applicant**  
**Health Care Provider - Medical Verification Form**

5. Please have a discussion with your patient about their job functions and review any job description and/or Position Description Questionnaire (“PDQ”) your patient has to provide. Describe the job function(s) and/or job facilities your patient is having trouble performing or accessing because of the limitations discussed above.

6. Please provide a recommendation of one or more reasonable accommodations that will enable your patient to perform the essential functions of their position. **See #9 below for leave accommodations.**

**UNLV Office of Benefits and HR Operations ADA  
Accommodation Applicant  
Health Care Provider - Medical Verification Form**

7. Please estimate but provide as specific as possible at least how long the accommodations will be necessary (you may provide that the accommodations will be necessary at least until a specific date, subject to improvements in the patient's condition and future appointments that you have with them).

The Accommodations will be necessary at least until the following date \_\_\_\_\_

8. Please discuss how that recommended accommodation(s) will allow your patient to perform the essential functions of their position.

**UNLV Office of Benefits and HR Operations ADA  
Accommodation Applicant  
Health Care Provider - Medical Verification Form**

9. Leave Accommodations (complete if applicable):

\_\_\_\_\_ Provide "yes" here if your recommended accommodation is leave because your patient is presently unable to perform their job.

Provide the minimum length of time your patient will need to be on leave because they are unable to perform the functions of their job. If possible, please estimate a date that your patient will be able to return to work.

Length of Time on Leave: \_\_\_\_\_

Date of Estimated Return to Work: \_\_\_\_\_

- If the return to work will be known after a follow up appointment with your patient occurs, please state when that follow up appointment will be below:

Follow Up Appointment Date: \_\_\_\_\_

- a. If known now and not otherwise addressed above, please estimate what restrictions or job modifications will be necessary when your patient is approved to return to work (Note, this information can be provided if applicable at a date closer to the patient's return to work):

\_\_\_\_\_  
**Signature Required** - Health Care Provider's Signature      Date



---

HUMAN RESOURCES

Americans with Disabilities Act Medical/Healthcare Information Release Form

This form will not be placed in your employment record file. Please submit a Medical/Healthcare Information Release Form for each healthcare provider you authorize to release information.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical ID/Patient Number or Last 4 digits of Social Security: \_\_\_\_\_

Name and Title of Healthcare Provider: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Address of Facility:

---

Brief description of disability/limitations for which you are requesting an accommodation:

---

I do hereby authorize the University of Nevada, Las Vegas Benefits and HR Operations office to communicate verbally and in writing, if necessary, with the appropriate healthcare or rehabilitation professionals with regard to the resolution of my request for a disability accommodation. My signature indicates that I am aware of the nature of the information being disclosed and with whom it will be shared.

A complete photocopy of this authorization shall be accepted as if it were signed original and is valid from the date of this release until the University completes its evaluation of my request for accommodation(s) of this condition.

I release the above-named Physician/Medical Professional from any liability associated with the disclosure of confidential or privileged medical/healthcare information. I understand that the University of Nevada, Las Vegas Benefits and HR Operations office cannot properly evaluate my request for accommodations unless I sign this release and that any information disclosed under this release could potentially be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

I understand that I may revoke this release in writing at any time by sending written revocation of authorization to: ADA Administrator, Benefits and HR Operations UNLV, 4505 S. Maryland Parkway Box 451026, Las Vegas, NV. 89154-1026.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_