Human Resources Department

Medical Information Request Form

for Medical Providers of Marquette University Faculty and Staff Employees

To Marquette University employees:

- Employees must complete Section I below and have your medical provider complete Section II.
- Please return completed forms to the Human Resources department via email humanresources@marquette.edu or fax: (414) 288-7425.
- For questions please contact the Human Resources department at (414) 288-7305.

Section I: To be completed by faculty or staff employee:

_____ _____ _____

Employee Name Phone Number Job Title

_____ _____

Department Supervisor Name

Identify and describe the physical or mental disability, illness, condition, or disease that is the basis for your request for reasonable accommodation or alternative work arrangement by the University.

Describe essential functions of your job you are unable to perform and the reasons why:

Release of Information:

I hereby authorize the release of the following information to Marquette University for the purpose of determining the availability of reasonable workplace accommodations or alternative work arrangements. I further authorize Marquette University to seek clarification of this documentation, if necessary, by contacting my physician or health care provider. I understand that Marquette University is not obligated to provide any specific accommodation I request but will evaluate my request in light of all information available in making a determination of what constitutes a reasonable accommodation or alternative work arrangement.

_____ _____

Signature Date

Section II: To be completed by the physician or health care provider:

To Physician or Health Care Provider:

To initiate a request for reasonable accommodations or alternative work arrangements, employees must provide current documentation of a disability or underlying health condition that may place them at higher risk for serious complications due to the COVID-19 virus. As the employee's physician or healthcare 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.

You should consider the employee's job functions and other information relevant to the employee's job at Marquette University. If this information has not been provided, please contact the employee, and let him or her know you cannot complete this form without that information.

COVID-19 and "higher risk categories" – The Centers for Disease Control (CDC) has identified several groups whose underlying medical conditions place them at a higher risk for severe illness from COVID-19. Please refer to the CDC website for the latest information about these higher risk categories and how they may pertain to your patient.

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. Thank you for your assistance.

_____ _____

Employee Name Date

1. Is the employee currently under your care? ☐ Yes ☐ No

2. When did you last see this employee? _____

3. What is the underlying condition/impairment for which the patient is requesting an accommodation or alternative work arrangement? Please refer to the CDC website for the latest information about higher-risk categories.

4. How does this underlying condition/impairment impact the employee's ability to perform the essential functions of his/her job?

5. Does the impairment substantially limit a major life activity as defined by the ADA?
   If yes, what major life activity as defined by the ADA is substantially limited?

6. Is this condition temporary, permanent, or unknown?
   If this condition is temporary, until what anticipated date is an accommodation or alternate work needed?

7. Please identify accommodations or alternative work arrangements that could enable the employee to perform his/her work.

Accommodation or alternative work arrangement	Justification	Recommended duration for this accommodation/alternative work arrangement

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

_____ _____

Signature of physician or health care provider Date

_____ _____

Professional's Name (printed) License Number

_____ _____

Professional's Title Telephone Number

_____ _____

Address Fax Number

Marquette University Human Resources Department
Email: humanresources@marquette.edu
Phone: (414) 288-7305 or Fax: (414) 288-7425