In accordance with the Americans with Disabilities Act Amendments Act of 2008 and the Pregnant Workers Fairness Act of 2017, Boston University provides reasonable accommodations to qualified individuals with disabilities and those who are pregnant or have a pregnancy-related condition who require accommodations to safely and effectively perform the essential functions of their positions, or to participate in the employment application process.

You may make a request for a reasonable accommodation to your supervisor, and/or to the Executive Director of Equal Opportunity in the Equal Opportunity Office, whichever you feel is most appropriate. In the event that you make a request to your supervisor, the request will be forwarded to and reviewed with the Executive Director of Equal Opportunity. If you make the request directly to the Executive Director of Equal Opportunity, the request will be discussed with your supervisor to the degree necessary to properly evaluate the request and to implement any accommodation provided. You may request that the Executive Director of Equal Opportunity not disclose the nature of the disability to your supervisor. Whether, or to what degree, such a request can be honored will depend upon what information must be provided to your supervisor to allow him or her to assist in the decision regarding appropriate accommodations.

To begin the accommodation request process, please provide the information requested below, and submit this form to your supervisor (non-faculty employees), your department chairman or dean (faculty employees), or to the Equal Opportunity Office. You may also contact the Executive Director of Equal Opportunity in the Equal Opportunity Office to discuss your request, either before or after submitting the form.

When you make a request for reasonable accommodation, you may be required to provide additional information from a medical provider documenting your condition, any limitations related to the condition, and the need for the accommodation requested. If such documentation is needed, your supervisor or the Executive Director of Equal Opportunity will request it from you during the process of evaluating your accommodation request. It is not necessary to provide the medical documentation when you submit this Accommodation Request Form. If you are provided with an accommodation, you may also be required to provide updated medical information at a later date. Please do not provide any genetic information on this form or if you are asked to provide medical information to support your request for accommodation. Federal law prohibits employers from requesting genetic information of an employee or an employee’s family member unless an exception applies. ‘Genetic information’ includes your family medical history, the results of your or your family member’s genetic tests, the fact that you or your family member sought or received genetic services, and genetic information of a fetus or embryo.

Revised 1/31/20
BOSTON UNIVERSITY
ACCOMMODATION REQUEST FORM

Your request for a reasonable accommodation, and any information submitted in support of or related to the request, will be kept confidential, except that it will be shared with those University officials who are involved in evaluating and/or implementing the request.

Any questions regarding the reasonable accommodation policy or process should be directed to Mary Ann Phillips, Assistant Director for Compliance, Equal Opportunity Office, 888 Commonwealth Ave, maryannp@bu.edu. FOR ADDITIONAL INFORMATION AND INSTRUCTIONS, PLEASE VISIT THE REASONABLE ACCOMMODATION SECTION OF THE EQUAL OPPORTUNITY WEB SITE RETURN THIS FORM TO Equal Opportunity Office, at the address above, or by Fax: 617-358-0490.

TO BE COMPLETED BY THE EMPLOYEE:

Name:_________________________________________________ Date:________________________________

Personal/Work Email:_________________________________ Cellphone #:__________________________

Campus Address:____________________________________ Work Telephone #:______________________

Department:________________________________________ Position:_______________________________

Supervisor:________________________________________ Supervisor Telephone #:____________________

1. Please describe the disability or serious medical condition(s) for which you are requesting an accommodation:

2. Is this condition temporary or permanent? ________________________

   a. If temporary, what is the anticipated length of need for accommodation?
3. Please describe any limitations resulting from your disability or serious medical condition(s) that interfere with your ability to perform the essential functions of your position:

4. Please select the workplace accommodations you believe you would need to enable you to perform the essential functions of your position (choose all that may apply):

☐ Medical leave/extension of medical leave:_____________________________________
☐ Modified work schedule:____________________________________________________
☐ Purchase or modification of equipment or assistive devices:_____________________
☐ ASL interpreters or CART:__________________________________________________
☐ Other (please describe): _____________________________________________________

5. If you are requesting a medical leave, please answer the following:
   a. Is your need for leave full time or intermittent? ____________________________

   b. What is the expected duration of your requested leave?

   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

TO BE COMPLETED BY THE ASSISTANT DIRECTOR OF EQUAL OPPORTUNITY:

Date request received by Equal Opportunity Office:

Action taken:

Date employee informed of action:
Request for Medical Information for ADA Accommodations

Name: ___________________________ DOB: _________________ Today’s Date: _____________

Dear Healthcare Provider,
Your patient is employed at Boston University and has requested an accommodation in the workplace. We require additional specific medical information to be able to review this request. Please provide complete, specific and legible answers to the questions below. Thank you for assisting your patient and Boston University.

BU Clinician: __________________________

ATTENTION Treating Provider: you are required to submit medical records including objective test results and narratives associated with this condition/diagnosis and treatment. YES__________NO__________

I authorize my provider to release the requested information to the Boston University clinician, identified above.
Patient Signature: ______________________________________ Date: _________________

Health Care Provider: Please complete the information below and submit this and any additional clinical information requested to confidential FAX at BUOHC: 844-537-3577

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
   a. If yes, what is the impairment or the nature of the impairment?

2. Does the impairment substantially limit a major life activity as compared to most people in the general population?
   ☐ Yes ☐ No
   a. If yes, what major life activity(s) (includes major bodily functions) is/are affected?

   b. Major bodily functions:

   ☐ Bladder   ☐ Digestive   ☐ Lymphatic   ☐ Reproductive
   ☐ Bowel     ☐ Endocrine   ☐ Musculoskeletal ☐ Respiratory
   ☐ Brain     ☐ Genitourinary ☐ Neurological ☐ Special Sense Organs & Skin
   ☐ Cardiovascular ☐ Hemic     ☐ Normal Cell Growth ☐ Other: (describe)
   ☐ Circulatory ☐ Immune     ☐ Operation of an Organ
3. Does employee require leave?  ☐ Yes  ☐ No

   a. If yes, how much leave will the employee need?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   b. Date employee can return to work with or without accommodation: ___________________________

4. Does your patient require job restrictions or accommodations to perform the essential functions of their job?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

5. How would your suggestions improve the employee’s job performance?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

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.

I hereby acknowledge and verify by my signature that the information provided is accurate, complete, and current.

MD/NP/PA/DO Signature: _____________________________________________ Date:_______________________

Print Physician Name: _________________________________________________________________________

State/License #_______________________________________________________________________________

Address:____________________________________________________________________________________

Phone:____________________________________________Fax:______________________________________