Medical Information Request Form

for Medical Providers of Jackson Public School District Facility and Staff

To JPS Faculty and Staff:

- Employees are to complete Section I below, provide details about the essential functions of their job to their medical provider and have the medical provider complete Section II.
- The Medical Information Request form is to be completed by the employee and the employee's physician or health care provider prior to completing the **ADA Reasonable Accommodation Form.**
- **Completed forms must be uploaded with your online ADA Accommodation Request Form**. For questions, please call JPS Human Resources at **(601) 960-8745**.

SECTION I (To be completed by Faculty or Staff):

Name	Job Title	School

Department	Supervisor

Release of Information

I hereby authorize the release of the following information to Jackson Public School District for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Jackson Public School District to seek clarification of this documentation, if necessary, by contacting my physician or health care provider.

Signature	Date

To the Physician or Health Care Provider:

To initiate a request for reasonable accommodations, employees must provide current documentation of a disability. 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.

To complete this form (see attached, page 2, section 2), you should consider the employee's job functions and other information relevant to the employee's job at Jackson Public School District. 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.

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.

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SECTION II (To be completed by the Physician or Healthcare Provider):

Patient's Name (First, MI, Last) _____

1. **Does the employee have a physical or mental impairment/disability?**

   ☐ YES ☐ NO

2. **If yes, what is the disability/impairment or the nature of the impairment/disability?**

3. **Does the employee have an underlying health condition?**

   ☐ YES ☐ NO

4. **If so, what is the underlying condition for which the patient is requesting the accommodation?**

☐ Serious Heart Condition	☐ Chronic Lung Disease (COPD)	☐ Chronic Kidney Disease Undergoing Dialysis
☐ Severe obesity (BMI ≥ 40)	☐ Type II Diabetes	☐ Immunocompromised (from solid organ transplant)
☐ Liver Disease	☐ Cancer	☐ Pregnancy
☐ Sickle Cell Disease	☐ Other: _____	

5. **Does the employee's condition or impairment/disability substantially limit a major life activity as compared to most people in the general population?**

   ☐ YES ☐ NO

6. **If so, please describe the employee's limitations as a result of the condition or impairment/disability:**

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7. **What essential job function(s) or benefits of employment (see attached Job Description) would the employee have trouble performing or accessing because of the limitation(s)?**

8. **Are you recommending a reasonable work accommodation for this employee?**

☐ YES ☐ NO

If so, what work accommodation(s) are you recommending for the employee based on the perceived limitations to their essential job functions (see attached Job Description) and what is the recommended duration for the accommodation(s)?

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 Health Care Provider **Date**

_____ _____
Provider name (printed) **Telephone #**

_____
Name and Location of Practice