UNIVERSITY OF WEST GEORGIA

Office of Legal Affairs
Title IX & Equal Opportunity

Medical Request for ADA Accommodations

Employee/Patient Name:_____ Date: _____

Provider Information:

Name: _____Title: _____
Name of Practice (if applicable)

Mailing Address_____
Street Address

_____
City State Zip Code

Phone Number (____)_____
Fax Number (____)_____

You have been identified as the above listed employee's/student's primary practitioner in which to consult regarding a medical condition that may require an accommodation in the workplace/classroom. In order for The University of West Georgia to proceed, we require information about the employee's/student's medical condition from a licensed health practitioner.

The Americans with Disabilities Act and the Title IX of the Education Amendments of 1972 requires employers/institutions to provide reasonable accommodations to employees/students who are pregnant or disabled, i.e., have a medical condition that substantially limits a major life function. We are requesting that you complete the attached form to determine if the employee/student is covered under the ADA/ Title IX, and if so, the nature of the condition and which major life activities it substantially limits. In addition, please advise us regarding what accommodations, if any, you believe the employee/student needs in order for him/her to perform his/her job duties and responsibilities. Enclosed is a copy of the employee's job description. If the requester is a student, no description will be given. The employee/student has also been asked to provide guidance as to what accommodations may be necessary.
Please fax the completed document to (770) 838-3495 or mail to the following address:

University of West Georgia
Office of Legal Affairs
ATTN: Brianna Baldwin
1601 Maple Street
Carrollton, GA 30117

If you have any questions, please contact Brianna Baldwin, Title IX Coordinator, at (678) 839-4977 or titleix@westga.edu

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1. Please describe the individual's health condition(s):

2. Please describe any impairments associated with the medical condition(s) and what major life activities they may limit. (Major life activities include but are not limited to caring for oneself, walking, seeing, hearing, speaking, performing manual tasks, breathing, learning, working, sitting, interacting with others, standing, lifting, thinking, concentrating, etc.)

3. Please describe recommended or potential job/educational accommodations for this individual based on their job description or status as a student.

4. Please provide the estimated time-frame that recommended accommodations may be needed.

Practitioner's Signature:

_____ Date Completed_____

Practitioner's Name (Please Print) _____

For Internal Use Only:

Date submitted to Physician's Office: _____Submitted by:_____

Submitted via:_____Mail/Fax____Address or Fax Number:_____

Enclosed Documents:____Health Information Release Waiver___Job Description