



REQUEST FOR REASONABLE
ADA ACCOMMODATION
Employee/Applicant

Employee/Applicant's Name: Position:

Address:

City/State: Zip Code:

Work Location: Work Telephone:

Date of Request for Accommodation:

ADA Accommodation Request

Please print or type. Be as specific as possible. If required, attach additional comments.

Multiple empty lines for providing details of the accommodation request.

The attached forms completed by my health care provider certifies the need for the requested ADA accommodation(s) and provides for the release of medical information, if necessary.

Employee/Applicant's Signature: Date:

For Office Use Only

Date Request Received:

Action Taken:

Administrative Official's Signature: Date:

- Copy to:
[] ADA Coordinator/Administrative Official
[] Judiciary Human Resources Department, Employee Relations, ADA Officer



State of Maryland Judiciary

Medical Inquiry and Release of Information Form for an **ADA Request**

A person has a disability under the Americans with Disabilities Act (ADA) if the person has an impairment that substantially limits one or more major life activities.

Does the employee have a physical or mental impairment? Yes No

Describe the impairment: _____

Under the ADA, a qualified employee may be entitled to a reasonable accommodation if the accommodation helps him/her to perform the essential functions of the job. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) interferes with his/her job performance?

What job function(s) does the limitation prevent the employee from performing?

What suggestions, if any, do you have that would enable this employee to perform the essential functions of his/her job?

Medical Professional's Signature

Date

Medical Professional's Printed Name

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize and request _____, health care provider, to provide any information regarding my medical condition as it relates to the performance of the essential functions of my job. I understand that this information will be used solely for the purpose of evaluating my request for reasonable accommodation and the information will remain strictly confidential. Disclosure will be made to those individuals necessary to aid in determining and implementing reasonable accommodations.

Employee's Signature

Date

Employee's Printed Name

Health Care Provider's Contact Information:

Name _____

Address _____

Phone _____

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.