# Equal Employment Opportunity Office
# COVID-19 Medical Information Request Form
*for Medical Providers of Vanderbilt Faculty, Staff, and Other Employees*

**To Vanderbilt Faculty, Staff, or other employees:**

- The Medical Information Request form is to be completed by the employee's physician or health care provider.
- 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.
- Completed forms are to be returned to: EEOO via direct submission, or faxed to: (615) 343-4709 or emailed to EEOOInfo@vanderbilt.edu. For questions, please call (615) 343-9336.

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

Name _____ Job Title _____ College or School _____

Department _____ Dean or Supervisor _____

**Release of Information**

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

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, 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 Vanderbilt. 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.

**Page 2, Section 2 Name** _____

1. What is the underlying condition for which the patient is requesting the accommodation?

☐ Serious heart condition ☐ Chronic lung disease/moderate to severe asthma ☐ Diabetes

☐ Severe obesity (BMI ≥40) ☐ Chronic kidney disease undergoing dialysis ☐ Immunocompromised

☐ Liver disease ☐ Other _____
(*Please specify)*

2. Are you recommending remote work as an accommodation?

☐ Yes ☐ No

If so, what is the recommended duration for the accommodation?

_____

3. If not recommending remote work, please identify accommodations that could enable the employee to perform his or her job duties.

- _____

_____ Duration_____

- _____

_____ Duration_____

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