FACULTY/STUDENT/RESIDENT REQUEST FOR ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT (ADA)

Purpose:

Form ADA-100 is used by an individual to submit a request for accommodation.

Processing Procedures:

1. The person requesting accommodation submits Form ADA-100 with a copy of the current position description (if appropriate) to the ADA Coordinator.

2. The ADA Coordinator will determine if additional medical information is needed and will furnish the person with any forms/questionnaires necessary for the health care provider to complete.

3. The ADA Coordinator will evaluate information to determine eligibility within the guidelines of ADA.

4. The ADA Coordinator will then coordinate with the necessary institutional staff and the individual to identify the essential functions of the position and determine whether there is an effective, reasonable accommodation that will enable the individual to perform the essential functions of the position.

5. The ADA Coordinator will follow-up on individual's status/progress on annual basis, or earlier as need arises.

Confidentiality:

All medical-related information shall be kept confidential and maintained separately from other student records. However, teachers, advisors and other individuals may be advised of information necessary to make the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.

Retention:

Forms ADA-100 and attached documentation submitted to the ADA Coordinator will be maintained in a confidential manner in accordance with applicable federal and state mandated retention schedules.

ADA Coordinator
Bonnie L. Blankmeyer, Ph.D.
Executive Director
Academic, Faculty and Student Ombudsperson
and ADA Compliance Office
Room 3.470T, Dental Building
Telephone: (210) 567-2691

(ADA-100)
FACULTY/STUDENT/RESIDENT REQUEST FOR ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT (ADA)

Individual Requesting Accommodation: _____

Position/Title: _____

Department/School: _____

Work Address: _____

Work Telephone Number: _____ Home Number: _____

Immediate Supervisor: _____ Phone Number: _____

ACCOMMODATION BEING REQUESTED: (use back to continue, if necessary)

_____

_____

_____

_____

_____

_____

REASON FOR ACCOMMODATION (identify condition and functional limitation(s) for which you seek an accommodation):

Condition: _____

_____

_____

_____

Functional limitation(s): _____

_____

_____

_____

INSTRUCTIONS FOR FACULTY/STUDENT/RESIDENT

PLEASE ATTACH OR PROMPTLY PROVIDE DOCUMENTATION FROM AN APPROPRIATE HEALTH CARE PROVIDER DESCRIBING YOUR FUNCTIONAL LIMITATIONS AND SPECIFYING THE MEDICAL CONDITION CAUSING THE FUNCTIONAL LIMITATIONS.

Faculty/Student/Resident Signature: _____ Date: _____

cc: ADA Coordinator

HEALTH CARE PROVIDERS INFORMATION
CONFIDENTIAL RECORDS STATEMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

INSTRUCTIONS FOR FACULTY/STUDENT/RESIDENT: Complete health care provider information and sign authorization release below. Make additional copies of this form for each of your health care providers, if you have more than one provider.

Sign and date all forms and return to:

Dr. Bonnie L. Blankmeyer
Executive Director
Academic, Faculty and Student Ombudsperson and ADA Compliance Office – MC 7735
7703 Floyd Curl Drive
San Antonio, Texas 78229-3900
Phone Number: (210) 567-2691

HEALTH CARE PROVIDER INFORMATION

Attending Health Care Provider's Name: _____

Attending Health Care Provider's Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (___) _____ Fax Number: (___) _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I have requested an accommodation from The University of Texas Health Science Center at San Antonio (UTHSCSA) under The Americans with Disabilities Act (ADA) of 1990.

I hereby authorize the ADA Coordinator for The UTHSCSA to communicate directly with the health care provider who completes this form, in order to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation.

This authorization will automatically end within one year from the date I sign this form.

Faculty/Student/Resident's Signature: _____ Date: _____

CONFIDENTIALITY NOTICE: Medical-related information shall be kept confidential and maintained separate from other personnel records. However, supervisors and managers may be advised of information necessary to the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.