



OFFICE OF  
**EQUAL OPPORTUNITY  
AND ACCESS**  
*Illinois State University*

RE: \_\_\_\_\_  
**(Name of person requesting a reasonable accommodation)**

Dear Health Care Provider:

The above-named individual has requested an accommodation under the Americans with Disabilities Act and amendments (ADAA) based on their disability/medical condition. The accommodation cannot be processed without the requested information. It would be greatly appreciated if you could provide this information as soon as possible.

“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 documentation. ‘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.”

Please contact us if you have any questions or concerns. Thank you in advance for your assistance.

Sincerely,

Sarah Schafer  
Interim ADA Coordinator

Office of Equal Opportunity and Access  
Illinois State University  
310 Hovey Hall, Campus Box 1280  
Normal, IL 61790-1280  
Telephone: (309) 438-3383  
Fax: (309) 438-7395  
[EqualOpportunity@IllinoisState.edu](mailto:EqualOpportunity@IllinoisState.edu)

1. What is the individual's diagnosis?
  
2. Does the condition substantially limit a major life activity? If so, how?
  
3. Describe the nature and severity of the individual's impairment.
  
4. Is this impairment short-term or long-term?
  
5. If short-term, what is the duration of the impairment? (If unsure how long condition will last, please give your best estimate.)
  
6. If long-term, describe the long-term impact of the impairment. (If unsure how long condition will last, please give your best estimate.)
  
7. List medications (over the counter and prescribed) that this individual takes for the impairment and/or prosthetic devices used.

8. What are the side effects of the medication as it relates to this individual's job/testing?

9. What accommodations does this individual require to perform the essential job functions of their position, or complete employment application process?

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_