

Only supply information about the condition for which the employee is requesting reasonable accommodation under the Pregnant Workers Fairness Act (PWFA). All information provided is confidential.

To be completed by EMPLOYEE	Employee Name	D.O.B.	Employee ID
	Job Title:	Department:	
	Employee Signature:		Date:

INSTRUCTIONS: To be completed and signed by the treating health care provider whose practice area must include treatment of the condition for which the employee is requesting reasonable accommodation under the PWFA. Please provide thorough answers to all questions and then return the signed form to the Illinois State University Office of Equal Opportunity and Access (OEOA). Direct questions about the Employee's Essential Work Functions to OEOA.		
Treating Health Provider Name:	Specialization / Type of Practice:	
Address:	Fax No:	Phone No.:
Questions to help determine whether an employee is eligible for reasonable workplace accommodations under the PWFA.		
<div style="display: flex; justify-content: space-between;"> 1. Does the employee have a physical or mental impairment? Yes No </div>		
<div style="display: flex; justify-content: space-between;"> 2. Is it related to, affected by, or arising out of pregnancy, childbirth, or related medical conditions? Yes No </div>		
<div style="display: flex; justify-content: space-between;"> 3. Is a change or adjustment at work needed? Yes No </div>		
<div style="display: flex; justify-content: space-between;"> 4. If yes, what change is needed, and approximately how long will it be necessary? </div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div>		
SIGNATURE of TREATING HEALTHCARE PROVIDER: <i>**Stamps and Designee Signatures NOT Accepted**</i>		Date:

Completed forms should be returned to:
Carrie Pierson, Deputy ADA Coordinator, Office of Equal Opportunity and Access (OEOA)
Illinois State University
 Campus Box 1280, 310 Hovey Hall, Normal, IL 61790-1280 Tel: (309) 438-3383 | Fax: (309) 438-7395