IOWA | NURSING

Medical Information Request Form

Confidential

Student Information

A. Student Name: ____

B. The student is required to complete about ________hours per shift, averaging ________hours perweek.

C. Return completed form to Dr. Anita Nicholson, Associate Dean for Undergraduate Programs

Address 354 College of Nursing, The University of Iowa, Iowa City, IA 52242

Phone Number: 319-335-7115

Fax Number 319-335-9990

Treating Healthcare Provider Complete

1. What is the physical or mental health condition? ____
2. Are you the treating healthcare provider of this health condition? ☐Yes ☐No
3. Identify the major life activities below that are limited due to the health condition(s), the treatment for the health condition, or the side effect of medication for the health condition that may influence these major activities.

Limitation in the number of hours:

☐ Work no more than _________hours/**day**

☐ Work no more than _________hours/**week**

During Clinical Hours:

☐ Stand no more than _________hours

☐ Walk no more than _________hours

☐ Sit no more than __________hours

Frequently = 34%-66% of the time - Occasionally = 1%-33% of the time

☐ Lift up to _______ pounds

☐ Frequently or ☐ Occasionally

☐ Push/pull/force up to _______ pounds

☐ Frequently or ☐ Occasionally

☐ Bend, twist, stoop

☐ Frequently or ☐ Occasionally

☐ Reaching

☐ Frequently or ☐ Occasionally

Additional Major Life Activities:

☐ Concentration ☐ Think ☐ Hear ☐ Learn ☐ Performing Manual Tasks ☐ Caring for Oneself

☐ Interact with others ☐ Sleep ☐ Eat ☐ Read ☐ Communication ☐ Other __________________________

☐ Work ☐ Sight ☐ Breath ☐ Speak ☐ Major Bodily Functions (Please List) ______________________________

Explain:____

____

____

4. What is the impact on the student's ability to provide patient care?

____

____

5. What is the duration of the limitation as indicated in #3 above (estimate if unknown)?

____

_______________________	_______________________	_______________________	___________
Office Name of the Treating HealthCare Provider	Treating Healthcare Provider Printed Name	Treating Healthcare Practitioner Signature	Date

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 do 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 reproduction services.

Authorization for Release of Information

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Student Complete

I, ______________________________ hereby authorize _______________________ of ________________________________

Student — Medical Provider — Clinic

to discuss, disclose, and/or deliver to The University of Iowa College of Nursing:

Student Name: ____

Birthdate:___________________________ Telephone: (H)____________________(W)____________________________

Address: ____

Street — City — State — Zip

Covering the periods of healthcare services:

From (date):_______________________________________ To (date):____

The following released information will be used for the purpose of determining ability to provide patient care:

(check and initial applicable information)
_______MEDICAL
_______PSYCHIATRIC
_______PSYCHOLOGICAL
_______OTHER:____

I understand that this information will include (check and initial, if applicable):

_______ Acquired Immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
_______ Behavioral health service/psychiatric care.
_______ Treatment for alcohol and/or drug abuse.

Affirmation of Release:
I give or the named agency permission to release only the information I have selected on this form to the individuals I have named and only for the purpose identified. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand any action on my part to deny access to information that is essential to the determination of reasonable accommodation(s) may nullify the accommodation process and influence employment decisions. The revocation will take effect on the day it is received in writing. I further understand that the members of the Faculty and Staff Disability Services office receiving this information are not health care providers, a health plan or health care clearinghouse and may not be covered by the federal privacy regulations.

____ ______________

Employee/Applicant Signature — Date

____ ______________

Witness Signature — *Relationship to Employee/Applicant* — *Date*

Last Updated January2014