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 per week.

C. Return completed form to Dr. Mary Tobin, Associate Dean for Undergraduate Programs

D. Address 239 College of Nursing, The University of Iowa, Iowa City, IA 52242

Phone Number: 319-335-2600

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*