

Employee Accommodation Medical Form

Please fax completed document to **631-632-9428**

## **Employee Information:**

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| --- | --- |
| **Name**: | **SBUID**: |
| **Title**: |  |
| **Department**: | **Supervisor**: |
| **Work Address**: | |
| **Location**: | **Preferred Contact Number**: |
| **Email Address**: | |
| **Are you currently on short term disability?** | |
| I hereby authorize the below referenced health care provider, facility or other appropriate professional to disclose to Stony Brook University/Stony Brook University Hospital/LISVH any information about my medical, physical or mental condition for the purpose of providing evidence related to my application for reasonable accommodation due to disability under applicable state and federal laws. Furthermore, I allow follow-up with the healthcare provider for clarity and discussion in relation to the accommodation process as appropriate. | |
| Signature: | Date: |

**AUTHORIZED HEALTH CARE PROVIDER, FACILITY OR OTHER APPROPRIATE PROFESSIONAL**

## *Please leave blank any sections of this form that are not necessary to document the underlying disability or the recommended accommodation.*

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|  |  |
| --- | --- |
| **Name(s) (please include all individuals / facilities authorized)**: | |
|  | |
| **Admission/Treatments Date(s)**: | **Discharge Date(s)**: |

*To be completed by a healthcare provider, facility or other appropriate professional.*

**PROVIDER, FACILITY OR OTHER APPROPRIATE PROFESSIONAL CONTACT INFORMATION**

|  |  |
| --- | --- |
| **Address**: | |
|  | |
| **Phone**: | **Fax**: |
| **Email**: | |

**DISABILITY DEFINITION:** For reasonable accommodation under the ADA and the NYS Human Rights Law, an individual has a disability if they have a medical, physical or mental impairment that substantially limits one or more major life activities or a record of such an impairment.

***Important Instructions for Professional Individual(s) Completing this Form:***

1. Under the ADA, Stony Brook University may only require necessary medical documentation. Please complete the sections beginning on page 3 of this form necessary to document the disability accommodation request. Please leave blank any sections of this form that are not necessary to documenting the underlying disability or the recommended accommodation.

2. ***The Genetic Information Non-Discrimination Act of 2008 (GINA)*** *prohibits employers from requesting or requiring genetic information of an individual or family member of an individuals, except where specifically allowed by law. Please do not include any genetic information, including family medical history, when completing this form.*

**IDENTIFICATION OF IMPAIRMENT:**

**Does the individual have a medical, physical or mental impairment?**

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| --- |
| **If yes, what is the impairment or the nature of the impairment?** |
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**INFORMATION REGARDING IMPAIRMENT: (Complete ONLY AS NECESSARY to document Impairment):**

Answer the following question based on what limitations the employee has when their condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

**Does the impairment substantially limit a major life activity as compared to most people in the general population?**

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| --- |
| **Describe the individual’s limitations when the impairment is active?** |
|  |
| **If yes, what major life activity(s) is/are affected?** |
|  |

**IMPACT ON JOB FUNCTIONALITY OR ACCESSING EMPLOYMENT BENEFITS**

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| --- |
| **Taking into account your review of this patient's job description or performance plan, what job function(s) or benefits of employment is the individual having trouble performing or accessing because of the impairment**? If a job description is unavailable, please request from the patient, through an interview, what are their job duties, including what barrier they are facing while trying to perform them. |
|  |
| **How does the individual’s impairment(s) interfere with his or her ability to perform the job function(s) or access a benefit of employment?** |
|  |

**RECOMMENDED ACCOMMODATION**

*By completing the below section, I acknowledged that I have reviewed this patient's job description and/or performance program in relation to my recommendation.*

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| --- |
| **Based upon your review of the patient’s job description or performance plan, please include here any suggestions you may have regarding possible accommodations that might improve job performance or access?** If a job description is unavailable, please request from the patient, through an interview, what are their job duties. |
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|  |
| **How could these suggestions improve performance or ability to access job benefits?** |
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| **Please indicate recommended duration for accommodation:** |

**Other Questions or Comments – Please feel free to attach additional sheets.**

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| --- | --- |
|  | |
|  | |
|  | |
| Medical Professional’s Signature | Date |

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