HEALTH CARE PROVIDER
ACCOMMODATION ASSESSMENT FORM

TO BE COMPLETED BY EMPLOYEE

Name _____ Empl. ID # _____

College _____

Contract Title _____ Department _____

☐ Job Description providing essential functions is attached

TO BE COMPLETED BY JOB APPLICANT

Name _____ Job ID # _____

College _____

Consent to Release or Discuss Health Information:

I hereby authorize my health care provider to release or discuss records and information regarding my physical or mental health to The City University of New York (CUNY) for evaluation of my request for employment-related reasonable accommodations. In addition, by my signature, I hold harmless any and all parties providing information to the University as a result of this authorization.

Signature _____ Date _____

INSTRUCTIONS TO HEALTH CARE PROVIDER

The above-referenced individual, whom we understand is your patient, has recently requested an accommodation. This necessitates that we evaluate the individual's physical or mental condition, in order to determine the individual's ability to perform the essential functions of the position, with or without reasonable accommodation. The essential functions of the job are set forth in the ATTACHED JOB DESCRIPTION.

The information provided by you will enable CUNY to engage in an interactive process with the individual (and with you or your designee, if required), to determine if a reasonable accommodation is necessary and, if so, the type of accommodation.

Please understand that CUNY complies fully with the Americans with Disabilities Act, and state and local laws prohibiting discrimination against individuals with disabilities. The information you provide will be kept confidential and used solely in accordance with these laws.

Your patient has signed the above authorization for you to release this information to us. Please DO NOT provide any Genetic Information about the individual or the individual's family members.

Your assistance in the completion of this form is greatly appreciated.

PLEASE PRINT CLEARLY OR TYPE YOUR RESPONSES.

SIGN THE FORM ON THE LAST PAGE (PAGE 3).

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TO BE COMPLETED BY HEALTH CARE PROVIDER

1. Does your patient have a physical or mental impairment that substantially limits one or more major life activities, such as, for example, self-care, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, sitting, standing, lifting, reading, etc. ?

☐ Yes
☐ No

If yes, please explain which major life activities are affected?

2. Is this condition ☐ Temporary ☐ Permanent

3. Does your patient have a physical, mental or medical impairment, infirmity or condition that is demonstrable by accepted clinical or laboratory diagnostic techniques?

☐ Yes
☐ No

4. Please list the functional limitations which result from the patient's impairment, infirmity, or condition.
(Example: Patient is unable to sit for long periods of time.)

5. After reviewing the attached job description, please describe how your patient's impairment, infirmity, or condition limits the patient's ability to perform the essential functions of the job. Please specify the essential job functions you believe your patient cannot perform.

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6. Do you believe a job modification or other work accommodation will enable your patient to perform the essential functions of the position?

☐ Yes
☐ No

7. If the answer to Question 6 is YES, please describe the job modifications or work accommodations that you believe would enable your patient to perform the essential functions of the position.

Also, if known, please indicate the estimated time/duration of the need for the job modification or accommodation.

Name of Health Care Provider

Address

City State Zip Code

Phone Number

License #

Signature of Health Care Provider

Date