Northeastern
Human Resources Management

Medical Documentation and Authorization Form
Request for Accommodation

I. Employee/Applicant:

Please complete this section and present this form and your job description to your medical professional. Ask the medical professional to complete this form and return it to Human Resource Management:

Name: _____ Gender: ☐ Male ☐ Female
Department/Unit _____ Position/Title: _____
Current Work Schedule/Shift: _____

I hereby authorize the release to Northeastern University of any medical documentation, records and information pertaining to my medical condition for the purpose of processing my request for workplace accommodation.

Employee Signature: _____

Date: _____

II. Medical Professional:

Complete this section and return it to:

Northeastern University
ADA, Human Resource Management
716 Columbus Avenue, Suite 250
Boston, MA 02120
Fax: 617-373-7610
Email: hrm_ada@northeastern.edu

Your patient has requested a workplace accommodation based on his/her medical condition. Northeastern University will consider a request for workplace accommodation if the documentation received demonstrates that the individual has a disability/handicap covered under federal, state, or local laws. To determine eligibility for workplace accommodation, the University requires current and specific documentation of the employee's medical condition from the diagnosing physician or health care provider. The information you provide is very important in allowing the University to make a proper determination related to this request. Please be as specific as possible in documenting the existence of

a particular medical condition. In addition, please review the job description and/or classification specification prior to completing this form.

All responses to the questions contained herein should pertain to the medical conditions related to the disability(s)/handicap(s). Please do not provide any medical information other than the information requested to assess the existence and scope of the disability/handicap and the need for accommodations(s).

Failure to complete this form completely and legibly will result in a delay in the consideration of your patient's request for accommodation.

Please respond to the following questions fully and accurately regarding your patient:

1. Describe the medical condition(s) for which accommodation is requested.

Conditions/diagnoses: (Must be ***current***)

Date of Onset**:** _____
Diagnosis: _____

_____

_____

☐ Permanent

☐ Temporary
If temporary, expected end date: _____

☐ Recurring
If recurring, how often are the recurrences expected?

_____

2. Does the patient's medical condition(s) (with or without medical treatment) cause substantial impairment to a **MAJOR LIFE ACTIVITY**?

☐ YES ☐ NO

IF YES, check which **MAJOR LIFE ACTIVITY(S)**

☐ Seeing
☐ Hearing
☐ Speaking, Communicating
☐ Eating
☐ Sleeping
☐ Working
☐ Walking, Standing, Lifting, Bending
☐ Breathing
☐ Performing Manual Tasks
☐ Learning, Reading, Concentrating
☐ Caring for Self
☐ Other (Specify) _____

3. Does the patient's medical condition (with or without medical treatment) cause substantial impairment to a **MAJOR BODILY FUNCTION**?

☐ YES ☐ NO

IF YES, check which **MAJOR BODILY FUNCTION(S)**

☐ Immune System
☐ Endocrine
☐ Respiratory
☐ Other (Specify)_____
☐ Digestive, Bowel, Bladder
☐ Neurological, Brain
☐ Circulatory

4. Substantial and/or Significant Restrictions or Limitations:

Please describe how the employee's physical or mental condition substantially restricts his/her ability to be considered for a job, to perform the essential functions of his/her job, to gain access to the workplace or to access benefits and privileges of employment. In completing this section, please specify the nature, frequency/duration, and severity of the restriction (i.e. no lifting, pushing, or pulling more than 20 pounds; no standing more than 30 minutes per hour).

Restrictions or Limitations	**Frequency/Duration**	**Severity (Mild/Moderate/Sever**

5. Accommodations:

Please describe any accommodations your patient may require to be considered for a job, to perform the essential functions of his/her job, to gain access to the workplace or to access benefits and privileges of employment.

Please describe why the accommodation is necessary and how it will assist the patient to be considered for a job, to perform essential functions of his/her job, to gain access to the workplace, or to access benefits and privileges of employment (i.e.: ergonomically designed chair releases stress on herniated disk).

6. Physician/Health Care Provider Information:

Name and Title: _____

Name of Hospital/Practice: _____

Medical Specialty: _____

Address: _____

Telephone: _____

Signature: _____

Date: _____

_____ _____

SIGNATURE – PHYSCIAN/HEALTH CARE PROVIDER DATE:

Note: *Accommodations are provided on a case-by-case basis in accordance with the Americans with Disabilities Act, as amended in 2008. To qualify for an accommodation, the employee must have a current medical condition that substantially limits a major life activity. Also, the accommodation must be necessary and reasonable to enable the employee to perform the essential functions of his/her job. A diagnosis, in and of itself, does not automatically qualify an employee for an accommodation.*