Northeastern
Human Resources Management

COVID-19 Request for Accommodation
Medical Documentation and Authorization Form

Northeastern University is committed to equal opportunity in all aspects of employment for qualified disabled individuals. During the COVID-19 pandemic, the university will use this form to assist in determining whether, or to what extent, a reasonable temporary accommodation may be necessary for an individual to perform one or more essential functions of their job.

Please complete the following

☐ Via employee self-service file your "Self-Identification of Disability," http://my.northeastern.edu/ or you may follow the path:

my.northeastern.edu > Service and Links > Employee Self Service > Personal Information > Disability Status

I. Employee/Applicant:

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

Name: _____ Position/Title: _____
Department/Unit _____ Supervisor: _____
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 a temporary workplace accommodation during the COVID-19 pandemic.

Employee Signature: _____

Date: _____

II. Medical Professional:

Complete this section and return it to:

Northeastern University
ADA, Human Resources Management
Fax: 617-373-7610
Email: hrm_ada@northeastern.edu

Your patient has requested a temporary workplace accommodation during the COVID-19 pandemic based on their medical condition. To determine eligibility for a temporary workplace accommodation during the COVID-19 pandemic, the University requires current and specific documentation of the employee's medical condition from the diagnosing physician or health care provider. Please only provide medical information relevant to assess the existence and scope of the need for temporary accommodations(s).

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

1. Describe the medical condition(s) for which the temporary accommodation is requested.
Conditions/Diagnoses: (Must be ***current***)

Date of Diagnosis or Onset: _____
Diagnosis: _____

_____

_____

2. Given the current COVID-19 pandemic, does the patient's medical condition(s) cause substantial impairment to a **MAJOR LIFE ACTIVITY (e.g., seeing, hearing, speaking, eating, sleeping, working, walking, standing, lifting, bending, breathing, performing manual tasks, learning, reading, concentrating, or caring for self) or MAJOR BODILY FUNCTION (e.g., immune system, endocrine, respiratory, digestive, bowel, bladder, neurological, brain, or circulatory)**?

☐ YES ☐ NO

3. Substantial and/or Significant Restrictions or Limitations:

Please describe how the employee's physical or mental condition substantially restricts their ability to perform the essential functions of their job, to gain access to the workplace or to access benefits and privileges of employment.

Restrictions or Limitations	Frequency/Duration	Severity (Mild/Moderate/Severe)

4. Questions to help determine accommodation options:

Please describe any temporary accommodations you suggest that your patient may require to perform the essential functions of their job, to gain access to the workplace, or to access benefits and privileges of employment during the COVID-19 pandemic.

5. Physician/Health Care Provider Information:

Name and Title: _____
Name of Hospital/Practice: _____
Medical Specialty: _____
Address: _____
Telephone: _____

_____ _____
SIGNATURE – PHYSICIAN/HEALTH CARE PROVIDER DATE: