Northeastern University
Human Resources

Request for Accommodation - Medical Documentation Form

I. Employee/Applicant:

Please complete the first section of the form and provide the form to your healthcare provider. Please note, the healthcare provider must be qualified in evaluating your disability and familiar with your individual condition or treatment. Please inform your healthcare provider of your position at the University and essential job duties. Your provider can return this form to the University's ADA Program Manager in the Office of Human Resources.

Name: _____
Department/Unit:_____ Position/Title:_____
Work Schedule/Shift: _____

I hereby authorize the release to Northeastern University of any medical documentation, records and information pertaining to my physical or mental impairment(s) for the purpose of evaluating my request for workplace accommodation.

Employee Name (Printed): _____

Employee Signature: _____

Date: _____

II. Medical Professional:
Please complete this section and return it to:

Northeastern University
ADA, Office of Human Resources
716 Columbus Avenue, Suite 250
Boston, MA 02120
Fax: 617-373-7610
Email: hr_ada@northeastern.edu

Your patient has requested a workplace accommodation based on their physical or mental impairment(s) Northeastern University will consider a request for workplace accommodation in accordance with the Americans with Disabilities Act, as amended and any other applicable federal, state or local laws. To evaluate the request the University is seeking current and specific documentation of the employee's physical or mental impairment from the diagnosing physician or treating health care

provider. Please be as specific as possible in describing the existence of a disability as well as any corresponding limitations on the employee. Please consult with your patient regarding their position and essential job functions in preparing this form.

All responses to the questions contained herein should pertain to the condition for which the accommodation is requested. Please do not provide medical information unrelated to this condition or accommodation request.

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

Please respond to the following questions fully regarding your patient:

1. Describe the employee's physical or mental impairment(s) including but not limited to the medical condition(s) for which accommodation is requested. ‘

Date of Onset: _____

Description of Physical or Mental Impairment:_____

_____

☐ Permanent

☐ Temporary
If temporary, expected end date: _____

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

_____

2. Does the patient's impairment(s) substantially limit a major life activity (without regard to the helpful effects of medical treatment or other mitigating measures)

☐ YES ☐ NO

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

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

3. Does the patient's impairment substantially limit impact a major bodily function (without regard to mitigating measures)?

☐ YES ☐ NO

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

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

4. Restrictions or Limitations:

Please describe how the employee's impairment(s) limits or restricts the employee at work. 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).

_____
_____
_____
_____

5. Accommodations:

Please describe reasonable accommodations that will enable your patient to perform the essential functions of their job or access the benefits and privileges of employment. Please describe why the accommodation is needed how it will aid the employee.

_____

_____

6. Physician/Health Care Provider Information:

Printed Name and Title: _____
License Number: _____
Name of Hospital/Practice: _____
Medical Specialty: _____
Address: _____
Telephone/Fax: _____

_____ _____
SIGNATURE – PHYSCIAN/HEALTH CARE PROVIDER DATE: