QUEENS COLLEGE
Office of Human Resources

QUEENS COLLEGE OF THE CITY UNIVERSITY OF NEW YORK
DISABILITY ACCOMMODATION REQUEST
HEALTH CARE PROVIDER ASSESSMENT

Employee Name: _____

Job Title: _____

Department: _____

The above-referenced employee, who we understand is your patient, has recently requested an accommodation for a disability. We are in the process of evaluating the employee's eligibility for an accommodation, and the employee's ability to perform the essential functions of his/her position with a reasonable accommodation.

Your provision of the information requested below is greatly appreciated. Your patient's authorization for you to do so is below.

The essential functions of the employee's position are set forth on the attached job description.

1. In your view, does your patient have a physical or mental condition that substantially limits one or more of his major life activities, such as, for example, caring for him/herself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, sitting, standing, lifting, reading, etc. ?

_____ Yes _____ No

Please explain:

_____

_____

Is this condition temporary_____ or permanent_____?

Please provide anticipated period of impairment:

_____

_____

2. Please identify the functional limitations which you have assessed result from this condition. (Example: patient is unable to sit for more than X hours).

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3. Please provide your assessment of the manner in which the functional limitations identified above limit your patient's ability to perform the essential functions of his/her position articulated in the attached job description. Please specify the essential job function(s) at issue.

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4. Do you believe a job modification or other work accommodation will enable your patient to perform all the essential functions of his/her position?

☐ Yes ☐ No

If yes, please describe the suggested job modifications or other work accommodations and the manner in which you assess such modifications or other accommodations would enable your patient to perform the essential functions of his/her position.

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_____ _____

Name of Health Care Provider (print) Date

_____

Signature of Health Care Provider

Address/Phone Number of Health Care Provider:

_____

_____

Employee Consent:

I hereby authorize the release and discussion of any pertinent medical or psychological information regarding my physical or mental conditions required by Queens College of the City University of New York to permit the evaluation of the disability accommodation(s) I have requested. By my signature I authorize the release of information requested by the College and hold harmless any and all parties requesting and providing information pursuant to this authorization.

_____ _____

Name of Employee (Please Print) Date

_____

Employee Signature