

**SECTION I: TO BE COMPLETED BY EMPLOYEE**

 \_\_\_\_\_  
**Last Name**

 \_\_\_\_\_  
**First Name**

 \_\_\_\_\_  
**Middle Initial**

 \_\_\_\_\_  
**Position**

 \_\_\_\_\_  
**Department**

 \_\_\_\_\_  
**Date**
**SECTION II: TO BE COMPLETED BY EMPLOYEE'S PHYSICIAN. Please print legibly or type.**

The above-named employee at SUNY Buffalo State University has applied for a Reasonable Accommodation under the Americans with Disabilities Act (ADA). We require information from the treating physician in order to determine whether an accommodation is warranted and, if so, the type of accommodation. Under the ADA, an employee has a disability if they have an impairment that substantially limits one or more major life activities, or a record of such an impairment. For reference, attached, please find the employee's Essential Job Functions.

**A. Questions to help determine whether an employee has a disability:**

I have read a copy of the employee's job description.

 YES  
 NO

Does the employee/patient have a physical or mental impairment?

 YES  
 NO

If yes, what is the impairment? (Please be specific)

Is the impairment temporary?

 YES  
 NO

If temporary, what is the anticipated duration? (Please be specific)

Is the employee/patient receiving any treatment or medication to treat the condition(s)?

Please identify:

How long have you been treating the employee/patient for this condition?

Can the employee/patient work an eight-hour day?

 YES

 NO

If no, how many hours per day can patient work? \_\_\_\_\_

Answer the following question based on what limitations the employee/patient has when their condition is in an active state and what limitations the employee/patient would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

**Does the impairment substantially limit a major life activity as compared to most people in the general population?**
 YES  
 NO

*Note: Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.*



**If yes, what major life activity(s) (includes major bodily functions) is/are affected?**

- |  |  |                                   |                                   |  |
|--|--|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Bending         | <input type="checkbox"/> Hearing                 | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Breathing       | <input type="checkbox"/> Interacting w/ Others   | <input type="checkbox"/> Reading  | <input type="checkbox"/> Standing |  |
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Learning                | <input type="checkbox"/> Seeing   | <input type="checkbox"/> Thinking |  |
| <input type="checkbox"/> Concentrating   | <input type="checkbox"/> Lifting                 | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Walking  |  |
| <input type="checkbox"/> Eating          | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working  |  |

**Major bodily functions:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Genitourinary      | <input type="checkbox"/> Operation of an Organ       | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Bowel          | <input type="checkbox"/> Hemic              | <input type="checkbox"/> Reproductive                |   |
| <input type="checkbox"/> Brain          | <input type="checkbox"/> Immune             | <input type="checkbox"/> Respiratory                 |   |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Lymphatic          | <input type="checkbox"/> Special Sense Organs & Skin |   |
| <input type="checkbox"/> Circulatory    | <input type="checkbox"/> Musculoskeletal    |  |   |
| <input type="checkbox"/> Digestive      | <input type="checkbox"/> Neurological       |  |   |
| <input type="checkbox"/> Endocrine      | <input type="checkbox"/> Normal Cell Growth |  |   |

**Please describe the nature and extent of current limitations employee/patient's condition(s) impose on their ability to perform their job duties:**

Employee/patient is **NOT** currently limited in their ability to perform their job duties.  YES

Employee/patient **IS** currently limited in their ability to perform their job duties.  YES

**Explain using the chart below.**

Physical Capabilities Check all that apply	<5 Min.	<15 Min.	<30 Min.	<60 Min.	1 Hr	2 Hrs	3 Hrs	4 Hrs	5 Hrs	6 Hrs	7 Hrs	8 Hrs
Sitting												
Standing												
Walking												
Driving												
Stooping												
Climbing												
Crouching												
Kneeling												
Pulling												
Pushing												
Reaching Overhead												
Reaching below waist												
Twisting												
Fine Manipulation												
Simple Grasp												
Lifting	Not greater than _____ lbs.											
Carrying	Not greater than _____ lbs.											

**B. Questions to help determine whether an accommodation is needed:**

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. Accommodation ideas and suggestions are always welcome and can be helpful however, employers do get to choose the effective accommodation that will be provided for an employee, as outlined by the EEOC. To assist us in determining the most appropriate and effective accommodation(s), the employer needs to know what specific symptoms and functional limitations are creating barriers for the employee. The following questions may help determine whether the requested accommodation is needed because of the disability. Please answer the following with as much detail as possible.

**What limitation(s) is interfering with job performance or accessing a benefit of employment? (What is getting in the way of the employee doing their job?)**

**What specific job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?**

**How does the employee's limitation(s) interfere with their ability to perform the job function(s) or access a benefit of employment?**

**C. Questions to help determine effective accommodation options:**

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

**Do you have any suggestions regarding possible accommodations to improve job performance?**

YES  NO     **If yes, what are they?**

**How would your suggested accommodations improve the employee's job performance?**

**Is the employee/patient able to perform the above checked tasks on a rotational basis?**  YES  NO



<b>For how long will the accommodation be needed?</b>
<b>When should the accommodation be reassessed?</b>
<b>When is the employee/patient's next scheduled visit?</b>
<b>Other Comments:</b>

<b>Physician – Print Name</b>	<b>Address</b>
<b>Physician Signature</b>	<b>Date</b>

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Buffalo State College is committed to protecting and maintaining the privacy and confidentiality of information provided by, or on behalf of, employees and applicants with disabilities. In particular, State and federal laws mandate very strict limitations on the use of any medical information obtained through the reasonable accommodation process.

**Please return completed form to the Human Resource Management Office via Fax (716) 878-3068 or [hr@buffalostate.edu](mailto:hr@buffalostate.edu). Location: Buffalo State University 1300 Elmwood Ave, Buffalo New York 14222, Cleveland Hall 403**