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Health Care Provider Information
Reasonable Accommodation Request / Request for Medical Information

This form must be completed by the health care provider. All items require completion. Please print legibly or type.

A: Requestor

Last Name	**First Name**	**Middle Initial**
Position		**Date**

B: Questions to be completed by Medical/Health Care Provider:

Under the American with Disabilities Act Amendments Act of 2008 (ADAAA) and the NYS Human Rights Law a person has a disability (or record of) if the person has a physical or mental impairment that substantially limits one or more major life activities (that include "major bodily functions" such as digestive, neurological, respiratory, etc.). Please answer the following questions to assist the employer in determining whether this employee has a disability (use additional sheets if needed):

1. Does the employee have a physical or mental impairment(s) and if yes please provide diagnosis and describe the nature and severity of such impairment(s).

   Yes ☐ No ☐

2. When did the impairments(s) begin and is the impairments(s) (expected duration)
   Temporary ☐ permanent ☐ episodic ☐ in remission ☐
3. Date of most recent treatment or office visit:
4. If the impairment is temporary, how long with the impairment likely last?

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5. If the impairment is episodic or in remission, please explain.

6. Does this impairment(s) substantially affect one or more major life activities or function (i.e. standing, walking, sitting, hearing, speaking, lifting, memory, etc.) of this employee?
   Yes ☐ No ☐

   If yes, please list specifically the major life activities and describe how such is affected:

7. Please describe the functional limitations(s) of this employee caused by the condition(s) or impairments(s) listed above and the extent that the impairment limits the employee's ability to perform those activities.

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8. Please describe how the limitations(s) of this employee identified above, affects their ability to perform the job duties of their position or how does the employee's impairment(s) interfere with their ability to perform the job functions (see attached job description).

9. Please describe any recommended accommodations(s) that may enable this employee to perform their job duties or essential functions and explain he relationship of the accommodation to the functional limitation.

Medical Professional's Signature

Date

Print Name of Health Care Provider

Address

City, State Zip

Telephone Number

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities 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 University 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.