

Medical Condition Information from Licensed Health Practitioner for ADA Accommodations

Contact Information

Name _____ Title _____

Name of Practice (if applicable) _____

Mailing Address _____
 Street Address _____
 City _____ State _____ Zip Code _____

Phone Number (____) _____ Fax Number (____) _____

You have been identified as the above listed employee's primary practitioner in which to consult regarding a medical condition that may require an accommodation in the workplace. In order for Albany State University to proceed, we require information about the employee's medical condition from a licensed health practitioner. Enclosed is a copy of the *Health Information Release Waiver* form submitted by the employee authorizing a Human Resources Department representative to seek personal health information relating to any relevant medical condition(s).

The Americans with Disabilities Act requires employers to provide reasonable accommodations to employees who are disabled, i.e., have a medical condition that substantially limits a major life function. We are requesting that you complete the attached form to determine if the employee is covered under the ADA, and if so, the nature of the condition and which major life activities it substantially limits. In addition, please advise us regarding what accommodations, if any, you believe the employee needs in order for him/her to perform his/her job duties and responsibilities. Enclosed is a copy of the employee's job description. The employee has been asked to provide guidance as to what accommodations may be necessary.

After you have completed the medical documentation, please fax documents to 229.500-4909 or mail to the following address:

Albany State University
 Office of Human Resources, Benefits
 2400 Gillionville Road, Suite K111
 Albany, GA 31707

If you have any questions, please contact the Benefits Department at 229.500-3070.

For Internal Use Only:

Date submitted to Physician's Office Submitted by:

Submitted via: Fax Number Mail

Enclosed documents: Waiver of Information Form Job Description

Medical Condition Information from Licensed Health Practitioner for ADA Accommodations

1. What is the nature of the illness/condition? (If additional space is needed, please use the back of this form).

2. Check all major life functions that are limited as a result of illness/condition. Major life functions include, but are not limited to the following:

- | | | | | |
|--|------------------------------------|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Caring for oneself | <input type="checkbox"/> Walking | <input type="checkbox"/> Seeing | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speaking |
| <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> Breathing | <input type="checkbox"/> Learning | <input type="checkbox"/> Working | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Thinking | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Other(s) _____ | | | | |

3. How does the illness/condition affect each major life function checked above? (Provide an explanation for each major life function checked above). To what extent does the illness/condition limit the major life functions above? (Be specific).

4. How long do you anticipate these accommodations to be required?

Practitioner's Signature _____

Date Completed _____

Thanks for your assistance.