SUNY ONEONTA - HUMAN RESOURCES – ADA MEDICAL DOCUMENTATION
607-436-2509 (P) 607-436-2717 (F)

EMPLOYEE COMPLETE THE FOLLOWING:

I _____, authorize the release of the following information to SUNY Oneonta as it relates to my request for a reasonable accommodation.

Signature _____ Date _____

PROVIDER COMPLETE THE FOLLOWING:

DOES THIS INDIVIDUAL HAVE A PHYSICAL OR MENTAL IMPAIRMENT? (As per the ADA, an employee has a disability if they have an impairment that substantially limits one or more major life activity(ies) or they have a record of such impairment.)

- ☐ NO (Please STOP, sign bottom of page 2 and fax back to number above.)
- ☐ YES (Please complete the remainder of this form and fax back to number above.)

WHEN DID THE IMPAIRMENT(S) BEGIN?_____

HOW LONG IS/ARE IMPAIRMENT(S) EXPECTED TO LAST? _____

Please answer the following questions based on what limitation(s) the employee has when their condition is in an active state and what limitations the employee would have if no mitigating measures were used.

DO(ES) THE IMPAIRMENT(S) SUBSTANTIALLY LIMIT A MAJOR LIFE ACTIVITY? (An impairment does not need to significantly or severely restrict the individual to meet this standard.)

- ☐ NO (Please STOP, sign bottom of page 2 and fax back to number above.)
- ☐ YES (Please complete the remainder of this form and fax back to number above.)

WHAT MAJOR LIFE ACTIVITY(IES) IS/ARE AFFECTED?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking
☐ Breathing	☐ Interacting w/others	☐ Reading	☐ Standing
☐ Caring for self	☐ Learning	☐ Seeing	☐ Thinking
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking
☐ Eating	☐ Performing manual tasks	☐ Sleeping	☐ Working

☐ Other _____

WHAT MAJOR BODILY FUNCTION(S) IS/ARE AFFECTED?

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special sense
☐ Cardiovascular	☐ Hemic	☐ Normal cell growth	organs & skin
☐ Circulatory	☐ Immune	☐ Operation of an organ	

☐ Other _____

To help us determine whether an accommodation is needed, please note that an employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. While accommodation ideas and suggestions are welcome, the employer chooses the effective accommodation that will be provided. Your answers to the following questions may help us determine if an accommodation is needed because of a disability. Please provide as much detail as possible.

> When responding to the following, as required by law, please do not provide any genetic information, defined as including family medical history, results of the individual's or family members' genetic tests, whether the individual or a family member sought or received genetic services, and genetic information of a fetus carried by the individual or a family member or an embryo lawfully held by the individual or a family member receiving assistive reproductive services.

WHAT LIMITATION(S) IS/ARE INTERFERING WITH JOB PERFORMANCE OR ACCESSING BENEFIT(S) OF EMPLOYMENT? (What is getting in the way of the employee doing their job or accessing/using buildings, facilities, equipment, dining areas, etc.)

WHAT SPECIFIC JOB FUNCTION(S) OR BENEFIT(S) OF EMPLOYMENT IS THE EMPLOYEE HAVING TROUBLE PERFORMING OR ACCESSING BECAUSE OF THEIR LIMITATION(S)?

HOW DOES/DO THE EMPLOYEE'S LIMITATION(S) INTERFERE WITH THEIR ABILITY TO PERFORM THEIR JOB FUNCTION(S) OR ACCESS BENEFIT(S) OF EMPLOYMENT?

TO HELP US IDENTIFY EFFECTIVE ACCOMMODATION OPTIONS, WHAT SUGGESTIONS DO YOU HAVE, IF ANY, REGARDING POSSIBLE ACCOMMODATION(S) THAT WOULD HELP THIS EMPLOYEE IMPROVE THEIR JOB PERFORMANCE OR ACCESS BENEFIT(S) OF EMPLOYMENT?

HOW WOULD YOUR SUGGESTIONS IMPROVE THEIR PERFORMANCE OR THEIR ABILITY TO ACCESS BENEFIT(S) OF EMPLOYMENT?

_____ _____

Health care provider name (print) Address

_____ _____

Phone Fax

_____ _____

Signature Date