



# EMERSON COLLEGE

## Accommodation Request Medical Statement

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

We are requesting medical information (diagnosis and prognosis) which could be used to help determine: 1.) whether the employee meets the criteria for an individual with a disability under the Americans with Disabilities Act of 1990; and 2.) any reasonable accommodation which might enable the employee to fulfill the essential function of his/her job. In order to assist you in this process, the employee's Job Description is attached.

### Please provide the following information:

1. Does the employee have a physical or mental impairment? Yes  No

2. What is the impairment? \_\_\_\_\_

3. Is the impairment long-term or permanent? Yes  No

4. If not permanent, how long will the impairment likely last? \_\_\_\_\_

5. Does the impairment affect a major life activity? Yes  No

6. If yes, what major life activity(s) is/are affected?

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

7. Is the employee substantially limited in one or more of these major life activities? Yes  No

8. What limitation(s) is interfering with job performance?

9. What job function(s) is the employee having trouble performing because of the limitation(s)?



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10. How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

11. Do you have suggestions regarding possible accommodations to allow the employee to fulfill their essential job functions? If so, what are they?

12. How would your suggestions enable the employee to fulfill their essential job functions?

13. List any additional comments that will assist us in this evaluation.

As the employee's request for an accommodation is being evaluated, we may need you to provide us with more detailed information. Should this further information become necessary, you will be provided with a follow-up request specifying any additional information we will need from you.

Medical Professional's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for your assistance.