Amherst College
Office of Human Resources

Medical Information Request Form for Reasonable Accommodations

To initiate a request for a reasonable accommodation, an employee must:

- Submit the completed Reasonable Accommodation Request form and the Medical Information Request for Reasonable Accommodations Form to the Office of Human Resources.
- The Medical Information Request Form is to be completed by the employee's physician or care provider. Employees are to complete Section I below, provide a copy of their job description to their medical provider and have the medical provider complete Section II. All documents, including the employee's job description, must be attached to this form.
- Completed forms are to be returned to: Office of Human Resources, Amherst College P.O. Box 5000, Amherst, MA 01002-5000 or faxed to: (413) 542-2687. For questions, please call (413) 542-5403.
- Contents of this request are confidential and will only be shared as needed with the appropriate personnel to consider the implementation of a reasonable accommodation. All medical documentation will be kept confidential.

Section I: To be completed by the employee:

_____ _____
Employee Name Job Title

_____ _____
Department Supervisor

Release of Information

I hereby authorize the release of the following information to Amherst College for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Amherst College to seek clarification of this documentation if necessary by contacting my physician or care provider.

_____ _____
Employee Signature Date

Section II: To be completed by the physician or care provider:

The above-named employee has initiated a request for accommodations at Amherst College and must provide current medical documentation for review. Human Resources will use this documentation to determine whether this employee has a condition or combination of conditions that constitute a disability and whether the disability causes limitations for which the employee needs reasonable accommodation(s).

As the employee's physician or care provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary. To complete this form, you should review the employee's job functions and other information relevant to the employee's job at Amherst College. If those materials have not been provided, please contact the employee and let him or her know you cannot complete this form without those materials.

Note: The statutory definition of disability with respect to an individual is "a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment".

Employee Name: _____

1. What is the diagnosis or condition(s) that impact the employee's physical and/or cognitive function? *You must state the specific diagnosis, terms such as "suggest" or "is indicative of" are not acceptable*.

2. What is the evidence supporting the diagnosis(es)? *Please provide a copy of any test results supporting the diagnosis(es) or other information used to reach the diagnosis*.

3. How long has the employee experienced this condition?

4. What is the expected duration, stability, or progression of the condition(s)?

5. What specific physical and/or cognitive functioning is impacted or limited by the condition(s)? And what is the severity of that impact (mild/moderate/severe)? Please explain.

6. What is the current treatment/follow up plan?

7. If the employee is taking any medications, what if any, are the side effects of the medication?

8. By reviewing the attached information concerning the employee's job duties, please describe the effect or limitations the impairment has on the employee's ability to perform the job duties. *Please be very specific in noting the limitations on specific duties and responsibilities listed*.

- Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or others due to the impairment? Please elaborate.

9. What are the suggested accommodations that might enable the employee to perform their job duties?

10. What is the expected duration of the accommodations noted?

11. Additional comments.

Thank you for your assistance in providing this information so that we may assess the employee's request. We will contact your if further information is necessary. Please sign below.

_____ _____
Signature of physician or care provider Date

_____ _____
Physician or care provider name (please print) Telephone Number

_____ _____
License or Certification Agency/Institution Name

_____
Address