Request for Medical Information for ADA Accommodations

To be Completed by Physician:

Date: _____
Patient Name:_____ DOB:_____

Dear Health Care Provider:

Your patient is employed at the University of Scranton, and has requested accommodations in the workplace. We require additional specific information to be able to review the request. Please provide complete, specific and legible answers to the questions below. Thank you for assisting your patient and the University of Scranton.

I authorize my provider to release the requested information to the University of Scranton Executive Director for the Office of Equity and Diversity, Elizabeth M. Garcia.

Patient Signature:_____ Date:_____

Health Care Provider: Please complete the information below and submit this and any additional relevant information to Elizabeth M. Garcia at elizabeth.garcia2@scranton.edu or fax 570-941-6304.

1. Diagnosis and onset of diagnosis:

2. How long have you been treating the patient?

3. Is the condition stable, permanent or expected to improve?

4. Is the condition stable for the patient to return to work?

5. What is the patient's prognosis to full recovery or medical stability?

6. Does the patient require job restrictions or accommodations to perform the essential functions of their job? If so, please list the restrictions and accommodations. (Please refer to the attached job descriptions)

Additional medical information or comments related to the request for accommodations:

I hereby acknowledge and verify by my signature that the information provided is accurate, complete and current.

Medical Provider's Signature:_____ Date:_____
Print Medical Provider's Name:_____
State/License #: _____
Address: _____
Phone #: _____ Fax: _____