Yeshiva University

REASONABLE ACCOMMODATION
HEALTH CARE PROVIDER STATEMENT FORM

(THIS FORM TO BE COMPLETED BY THE HEALTH CARE PROVIDER)

Date: _____

Applicant/Employee Name: _____ **DOB**: _____

The above noted individual has requested a reasonable accommodation in order to participate in the job application process, perform the essential functions of a job, or to participate in other terms, conditions and privileges of employment. The information requested on this form will assist in making a determination regarding the individual's request.

INSTRUCTIONS: The following form must be completed in detail and signed by the health care provider. Please attach additional pages or records as needed. Do not provide information unrelated to the reasonable accommodation request. All information submitted will be kept confidential to the extent permitted by law. *

SECTION 1- HEALTH CARE PROVIDER INFORMATION

Name:	
Practice/Specialty:	**Phone #:**
Address:	**Email:**
Health Care Provider: List information pertaining to your applicable degrees, area(s) of specialization, board certifications, and/or licenses:	

SECTION 2 – VERIFICATION

Verification by a Health Care Provider must meet the following criteria:

a) Documentation must provide a confirmation of disability, or other medical-related need for accommodation, and include a medical recommendation for a specific reasonable accommodation. Note: Documentation need not include details of a medical diagnosis.

b) The documentation must be written on the official letterhead or other organizational form of the health care provider.

c) The health care provider's credentials must be identified.

d) The documentation must be dated and signed by the health care provider.

e) Describe the limitations in detail as they currently exist and only in relationship to the process/job, and state whether the disability, or other medical-related need for accommodation, is ongoing or temporary. If temporary, specify the date the disability, or other medical-related need for accommodation, is expected to no longer require an accommodation.

f) Indicate the extent to which the accommodation will permit the individual to participate in the job application process, perform the essential functions of the job, or to participate in other terms, conditions and privileges of employment.

g) If equipment purchase is recommended, please be specific. If work modification, restructuring or sharing of specific duties is recommended, describe the recommended action and be specific.

h) The identification and evaluation of the extent to which the individual's impairment poses a direct threat, if any, to the safety of themselves or others.

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. For more information about the GINA Act, please visit http://www.eeoc.gov/laws/types/genetic.cfm

Please forward all assessments, records & information to:
Yeshiva University, University Benefits
2495 Amsterdam Avenue, BH 824, New York, NY 10033 or via fax 212-960-0034