## REQUEST FOR MEDICAL INFORMATION

Form must be completed by health care provider. All items require completion. Please print legibly or type.

**A. To be completed by hired candidate/employee:**

______________________________________________

Last Name First Name Middle Initial

______________________________________________

Position Title Department

**B. Questions to be completed by Medical/Health Care Provider:**

*Under the Americans with Disabilities Act Amendments Act of 2008 (ADAAA) and the NYS Human Rights Law a person has a disability (or record of) if the person has a physical or mental impairment that substantially limits one or more major life activities (that include “major bodily functions” such as digestive, neurological, respiratory, etc.). Please answer the following questions to assist the employer in determining whether this employee has a disability (use additional sheets if needed):

1. Does the employee have a physical or mental impairment(s) and if yes please provide diagnosis and describe the nature and severity of such impairment(s):

☐ Yes ☐ No

______________________________________________

______________________________________________

______________________________________________

______________________________________________

2. When did the impairment(s) begin and is the impairment(s) (expected duration) ☐ temporary ☐ Permanent ☐ Episodic ☐ In remission? ______________________________

3. If this impairment is temporary, how long will the impairment likely last? ____________

4. If this impairment is episodic or in remission, please explain:

______________________________________________

______________________________________________

______________________________________________

5. Does this impairment(s) substantially affect one or more major life activities or function (ie. Standing, walking, sitting, hearing, speaking, lifting, memory, etc.) of this employee?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

6. Please describe the functional limitation(s) of this employee caused by condition(s) or impairment(s) listed above and the extent that the impairment limits the employee's ability to perform those activities:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

7. **Please describe how the limitation(s) of this employee identified above, affects his/her ability to perform the job duties of his/her position or how do(es) the employee's impairment(s) interfere with his/her ability to perform their job functions (see attached job description or standard)?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

8. Please describe any recommended accommodation(s) that may enable this employee to perform his/her job duties or essential functions and explain the relationship of the accommodation to the functional limitation:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

______________ ______________________________
Date Signature of Health Care Provider/Specialty

______________________________
Print Name of Health Care Provider

______________________________
Address

______________________________
Telephone No.

*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.** "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Potsdam is committed to protecting and maintaining the privacy and confidentiality of information provided by, or on behalf of, employees and applicants with disabilities. In particular, State and federal laws mandate very strict limitations on the use of any medical information obtained through the reasonable accommodation process.

June 2021