Cornell University

Office of Institutional Equity and Title IX
500 Day Hall, Ithaca, NY 14850
607-255-2242
equity@cornell.edu

Employee Disability Accommodation Request
Health Care Provider Verification Form

The employee must complete, sign, and date section 1 of this form and have a Health Care Provider/Practitioner complete, sign, and date sections 2 and 3. The completed form should be emailed to the Office of Institutional Equity and Title IX at equity@cornell.edu or sent via Cornell Secure File Transfer to Equity and Disability Specialist, Nina Drake, at nmd63@cornell.edu.

Section 1: To be Completed by Employee

Employee Information:

Name:_____ Pronouns:_____

Employee ID#:_____ NetID:_____

Job Title:_____ Date:_____

I do hereby authorize Cornell University Office of Institutional Equity and Title IX to communicate both verbally and in writing, if necessary, with the appropriate health care or rehabilitation professionals with regard to the resolution of my request for a disability accommodation. My signature indicates that I am aware of the nature of the information being disclosed and with whom it will be shared.

Signature:_____Date:_____

Section 2: To Be Completed by Health Care Provider

Health Care Provider Information:

Health Care Provider's Name: _____

Type of practice/medical specialty: _____

Certification or License #: _____

Telephone Number: _____ Fax Number: _____

Signature of Health Care Provider: _____ Date: _____

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Section 3: To be Completed by Health Care Provider

For reasonable accommodation under the ADA, an individual has a disability if they have a physical or mental impairment that substantially limits one or more major life activities or a record of such an impairment. Please answer the questions below to help determine disability and reasonable accommodation.

1. Please identify the impairment or the nature of the impairment for the above-named individual:

   _____

2. Is the impairment temporary or permanent? If temporary, how long will the impairment last?
   - ◯ Permanent
   - ◯ Temporary

   _____

3. Does the impairment substantially limit a major life activity?
   - ◯ Yes
   - ◯ No

4. If *yes*, what major life activity(s) (includes major bodily function) is/are affected?

   - ☐ Bending
   - ☐ Breathing
   - ☐ Caring For Self
   - ☐ Concentrating
   - ☐ Eating
   - ☐ Hearing
   - ☐ Interacting With Others
   - ☐ Learning
   - ☐ Lifting
   - ☐ Performing Manual Tasks
   - ☐ Reaching
   - ☐ Reading
   - ☐ Seeing
   - ☐ Sitting
   - ☐ Sleeping
   - ☐ Speaking
   - ☐ Standing
   - ☐ Thinking
   - ☐ Walking
   - ☐ Working
   - ☐ Other (describe): _____

   Major Bodily Functions:

   - ☐ Bladder
   - ☐ Bowel
   - ☐ Brain
   - ☐ Cardiovascular
   - ☐ Circulatory
   - ☐ Digestive
   - ☐ Endocrine
   - ☐ Genitourinary
   - ☐ Hemic
   - ☐ Immune
   - ☐ Lymphatic
   - ☐ Musculoskeletal
   - ☐ Neurological
   - ☐ Normal Cell Growth
   - ☐ Operation of an Organ
   - ☐ Reproductive
   - ☐ Respiratory
   - ☐ Special Sense Organs & Skin
   - ☐ Other (describe): _____

5. Describe any recommended accommodations. Be as specific as possible (i.e. a piece of office equipment or device, etc.)

   a. Purchase of Assistive Device(s): _____
   b. Removal of Communication Barrier: _____
   c. Removal of Architectural Barrier: _____
   d. Modified Work Schedule: _____
   e. Job Restructuring (the University is not required to reallocate essential job functions):
      _____
   f. Other:
      _____

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6. Please provide any other information that might help the Office of Institutional Equity and Title IX evaluate this request.

   _____
   _____
   _____
   _____

Signature of Health Care Provider: _____ Date: _____

If required, please use additional sheets for any of the information requested above.

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' as defined by GINA, 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 sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services