FROSTBURG STATE UNIVERSITY

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Medical Documentation and Authorization Form Request for Accommodation

Employee/Applicant: Please complete this section and present this form and your job description to your medical professional. Ask the medical professional to complete this form and return it to the ADA Compliance Officer:

Name: _____Gender: Male Female

Department: _____Position/Title: _____

Current Work Schedule/Shift: _____

I hereby authorize the release to Frostburg State University of any medical documentation, records and information pertaining to my medical condition for the purpose of processing my request for workplace accommodations.

Employee Signature: _____

Date: _____

Medical Professional:

Complete this section and return to:

Frostburg State University
ADA Compliance Officer
126 Hitchins Administration Building
Frostburg State University
Frostburg MD 21532

Your patient has requested a workplace accommodation based on his/her medical condition. Frostburg State University will consider a request for workplace accommodation if the

documentation received demonstrates that the individual has a disability covered under federal, state, or local laws. To determine eligibility for workplace accommodation, the University requires current and specific documentation of the employee's medical condition from the diagnosing physician or health care provider. The information you provide is very important in allowing the University to make a proper determination related to this request. Please be as specific as possible in documenting the existence of a particular medical condition. In addition, please review the job description and/or classification specification prior to completing this form. All responses to the questions contained herein should pertain to the medical conditions related to the disability(s). Please do not provide any medical information other than the information requested to assess the existence and scope of the disability and the need for accommodations.

Describe the medical condition(s) for which accommodation is requested.

Conditions/diagnoses: Date of Onset: _____

Diagnoses:

_____

□ Permanent

□ Temporary

□ Recurring
If recurring, how often are the recurrences expected? _____

Does the patient's medical condition(s) (with or without medical treatment) cause substantial impairment to a MAJOR LIFE ACTIVITY?

□ Yes □ No

IF YES, check which MAJOR LIFE ACTIVITY(S)

□ Seeing	□ Sleeping	□ Breathing
□ Hearing	□ Working	□ Pregnancy - Related
□ Communicating	□ Walking, Standing	□ Other (Specify)

☐ Eating ☐ Lifting or Bending

Does the patient's medical condition (with or without medical treatment) cause substantial impairment to a MAJOR BODILY FUNCTION?

☐ Yes ☐ No

IF YES, check which MAJOR BODILY FUNCTION(S)

☐ Immune System
☐ Endocrine
☐ Respiratory
☐ Neurological
☐ Digestive
☐ Circulatory
☐ Other (Specify)

Substantial and/or Significant Restrictions or Limitations:

Please describe how the employee's physical or mental condition substantially restricts his/her ability to be considered for a job, to perform the essential functions of his/her job, to gain access to the workplace or to access benefits and privileges of employment. In completing this section, please specify the nature, frequency/duration, and severity of the restriction (i.e. no lifting, pushing, or pulling more than 20 pounds; no standing more than 30 minutes per hour).

_____

_____

_____

_____

Accommodations:

Please describe any accommodations your patient may require to be considered for a job, to perform the essential functions of his/her job, to gain access to the workplace or to access benefits and privileges of employment.

_____

_____

_____

_____

Physician/Health Care Provider Information: _____

Name and Title: _____

Name of Practice: _____

Medical Specialty: _____

Address: _____

Telephone: _____

_____ _____

Signature Date