PHYSICIAN QUESTIONNAIRE AND DECLARATION
Part A: TO BE COMPLETED BY EMPLOYEE REQUESTING ACCOMMODATION

Name:	**Date of Birth:**
Address:	**Department:**
Home Telephone Number:	**Title:**
Cell Telephone Number:	**Supervisor:**

Physician Name:	**Physician Telephone Number:**
Physician Address:	**Physician Fax Number:**

By initialing here _____, I authorize_____
(Initials) (Name of individual health care provider)
to discuss my health information and to release my medical records, including patient histories, office notes, including psychotherapy notes, test results, radiology studies, films, referrals, consults, and records to Long Island University Human Resources. It is understood that some or all medical information may be shared, as deemed necessary by Long Island University Human Resources, with relevant University personnel in determining whether the University can provide an accommodation.

Signature:_____/Date:_____

Print Name:_____

PHYSICIAN QUESTIONNAIRE AND DECLARATION
Part B: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Physician Name: _____

Physician Specialty: _____

Address: _____

Phone: _____

Fax: _____

INSTRUCTIONS TO HEALTH CARE PROVIDER:

Your patient/our employee, _____, has made a Request for a reasonable workplace accommodation. In order to process this request, Long Island University needs your assistance with responding to the following questions:

Please feel free to attach additional pages if necessary.

1. Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position with or without a reasonable accommodation?
□Yes
□No, not at this time.

1.a. If no, how long will the employee be unable to perform these job duties?

_____# of weeks _____# of months _____permanently

1.b. If yes, what is the employee's anticipated return to work date? _____

2. Does the employee have a physical or mental impairment?
□Yes □No

If Yes, please answer the following:

2.a. What is the nature and severity of the impairment?
_____
_____
_____

2.b. What is your prognosis as to the duration of his/her condition?
_____
_____
_____

3. Please specify the job tasks and duties that you feel are being limited by the employee's impairment and please explain why the job tasks are being affected by the employee's impairment (i.e. driving, increases back pain).

_____
_____
_____
_____

4. Please indicate if there are any recommended reasonable accommodations for these tasks and duties. (i.e. no sitting greater than 20 minutes at a time without a break): *Please use additional paper if needed*

_____
_____
_____
_____

5. What job tasks and duties is the employee capable of performing without any limitations or restrictions? Please list all that apply.

_____
_____
_____
_____

6. Are the work limitations or work restrictions permanent in nature? □Yes □No

7. If the limitations/restrictions are **temporary**, please specify the anticipated disability duration. Start Date:_____ End Date:_____

8. Is the employee currently on medication that would interfere with the employee's ability to safely perform job functions without risk of harm to the employee or others in the workplace?
□Yes □No

9. Please comment if there is any other pertinent information which may assist us in facilitating the employee's ability to perform the essential functions of his/her job.

_____
_____
_____
_____

Physician Declaration: ***I understand that I am providing the requested information to assist Long Island University in determining whether it can provide an accommodation for my patient, _____. I certify that the information I am providing is true and correct and accurately reflects my medical assessment and opinion concerning_____.***

_____
Physician Name (please print clearly)

_____/_____
Physician Signature Date

To be completed by Department or HR:

Initial Rec'd Date:	Initially Rec'd By:
Copy Forwarded On:	Copies sent to: