KEAN
OFFICE OF HUMAN RESOURCES

MEDICAL ASSESSMENT FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

To be completed by your Health Care Provider

Employee Name: _____ Title/Dept: _____

Instructions – *To request an accommodation from Kean University due to your own medical condition pursuant to the Americans with Disabilities Act, please provide medical certification from your Health Care Provider (HCP) that addresses the following questions. The HCP may either use this form or may provide a detailed letter. This documentation may be faxed to the confidential fax line 908-737-3319 by your HCP. Questions may be addressed to Lorice Thompson-Greer (lgreer@kean.edu or 908-737-3309)*

Part A.

Does the employee have a physical or mental impairment? Yes ☐ No ☐

If *yes*, what is impairment or the nature of the impairment?

(Please include a statement or description of appropriate medical facts regarding the health condition for which the accommodation is requested. Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, any referrals for evaluation or treatment (physical therapy, for example) or any other regimen of continuing treatment.)

Part B.

(Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.)

Does this impairment substantially limit a major life activity as compared to most people in the general population? Yes ☐ No ☐

Or, Describe the employee's limitations when the impairment is active.

If *yes*, what major life activity(s) (includes major bodily functions) 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)

What is the expected duration of the employee's impairment? ☐ Temporary ☐ Permanent

If temporary, please indicate expected recovery date:

Part C.

Please describe how the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

Do you have any suggestions regarding possible accommodation to improve job performance? If so, what are they? How would your suggestions improve the employee's job performance? (You may describe your recommendations for restrictions, modifications, equipment, or adjustments to the employee's job duties or work environment and explain how each will address the work-related limitation.)

Please provide a timeline for these modifications/ accommodations:

☐ Temporary - if so, provide dates: _____

☐ Indefinite (expected to last 6 months or longer) ☐ Permanent ☐ Unknown

Would performing any of the job functions listed result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc)? ☐Yes ☐No

If yes, please describe which job function would pose such a threat, the direct threat or health threat posed, and any accommodation that might eliminate this direct safety or health threat.

By signing below, I certify that this information is true and accurate to the best of my knowledge.

Health Care Provider Signature	Print Name	Date
Specialty	Address	State/Zip

NOTE TO PHYSICIAN: *The Genetic Information Nondiscrimination Act of2008 (GINA) prohibits employers and other entitles 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.*