Employee Accommodation Healthcare Provider Questionnaire

The **Office of Accessibility Resources and Services (OARS)** is committed to providing reasonable accommodations in accordance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and relevant state and federal laws. An individual with a disability is defined as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

This form is to be used by an NJIT employee to request medical information from their healthcare provider. OARS will follow up directly with the employee to support the implementation and coordination of approved accommodations.

Pages 2-3 of the questionnaire must be completed by your healthcare provider.

TO BE COMPLETED BY EMPLOYEE:

The employee named below hereby consents and agrees that their treating healthcare provider may complete this medical questionnaire and that the employee's private medical information may be released to the employer, New Jersey Institute of Technology (NJIT), through the Office of Accessibility Resources and Services (OARS).

Please note: Your healthcare provider may require that you also sign a HIPAA Authorization form to release certain medical information. You have an obligation to cooperate in the interactive accommodation process, including authorizing the release of medical information necessary to evaluate a request for accommodation.

Name: NJIT UCID/ID #:

Status: NJIT Office/Department:

Staff
Faculty
Administration

Signature Date

The following two pages must be completed and signed by your healthcare provider.

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

The above-named employee is currently employed by NJIT. The employee has reported a disability and has requested an accommodation with our office. We currently are engaged in the interactive process with the employee regarding their request for an accommodation pursuant to the Americans with Disabilities Act (ADA) and New Jersey Law Against Discrimination (NJLAD).

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.

Please provide responses to the following:

1. Does the employee have a physical or mental disability?

   ☐ Yes ☐ No

2. If yes, please describe the physical or mental disability.

3. Please indicate the duration or expected duration of the disability:

   ☐ Temporary
   ☐ Permanent
   ☐ Special Circumstances

   If you selected Temporary or Special Circumstances, please include expected duration:

4. Does the disability limit or impede any major life activities for the employee?

   ☐ Yes ☐ No

   If yes, please describe the activities and how they are limited:

5. Please describe the functional limitations impacting their job duties including the frequency, severity, and duration.

6. Please describe any proposed reasonable accommodations based on your professional judgment and opinion. Include how these accommodations will address the employee's limitations and allow the employee to be able to perform job functions.

7. If leave is an accommodation, please advise on the duration and possible return date.

   If intermittent leave or leave due to "flare up" conditions arise, please advise on the frequency per month (days per week and/or time off):

PROVIDER/PHYSICIAN INFORMATION:

Provider/Physician Name:

Healthcare License #:

Address:

Telephone: Email Address:

Certification: *I certify this information is accurate and based on my professional judgment.*

Signature Date

Please return this form and supporting documentation to employee_accommodations@njit.edu