

## Disability Verification Form – Health Provider Statement

The employee indicated below has declared a disability and requested a reasonable accommodation in the workplace under the provisions of the Americans with Disabilities Act (ADA). The attached form is to be completed by the health care provider and should be submitted to the Office of Human Resources with the employee’s Reasonable Accommodation Request Form. The information sought is job-related and consistent with business necessity for the following reasons:

- to determine if the individual meets the ADA definition of “individual with a disability”;
- to determine if the individual is a qualified person under the ADA, meaning he or she can perform the essential functions of the job currently held (or held before the injury or illness), with or without reasonable accommodation, and without posing a “direct threat” to health and safety of self or others that cannot be reduced or eliminated by reasonable accommodation; and
- to identify an effective reasonable accommodation that would enable the individual to perform essential job functions in the current (or previous) job, or in a current vacant job for which the person is qualified (with or without accommodation).

The responsibility of making employment decisions or deciding whether it is possible to make a reasonable accommodation for a person with a disability lies with officials of the Community College of Rhode Island, not the health care provider.

### Medical Authorization (to be completed by the employee)

Employee Name: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize my health care provider to furnish the Community College of Rhode Island (hereinafter CCRI), 400 East Avenue, Warwick, Rhode Island 02886-1807, all medical information pertaining to my request for reasonable accommodation(s).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Disability Verification (to be completed by the Health Care Provider)**

Please describe the employee’s current health condition/disability:

Date condition/disability commenced: \_\_\_\_\_

Probable duration of condition/disability: \_\_\_\_\_

Does the employee’s medical condition result in a physical or mental impairment that substantially limits one or more “major life activities”?       Yes       No

If “yes” please describe the functional limitations; indicating which “major life activities” are affected:

Attached is a job description or information about the essential functions of the employee's position. Please circle any items listed on the job description that the employee may not be able to perform based on the employee's medical history and physical exam. Please indicate your opinion by selecting one of the following options:

- \_\_\_\_ Should be able to perform the essential job functions without accommodation
- \_\_\_\_ May not be able to perform the essential job functions circled on the attached job description and a reasonable accommodation is not feasible
- \_\_\_\_ May not be able to perform the essential job functions circled on the attached job description; however, the following reasonable accommodation(s) should be considered to help the individual perform the essential functions (please list your recommendation for reasonable accommodation):

(Optional) If necessary for the protection of the health and safety of this employee or others, please indicate special instructions for first-aid providers or supervisors:

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Health Care Provider

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number