Cornell University

Cornell Office of Civil Rights
500 Day Hall
Ithaca, NY 14853
Telephone & Fax: 607.255.2242
Email: accommodations@cornell.edu
Website: https://officeofcivilrights.cornell.edu

Employee ADA Accommodations Health Care Provider Questionnaire

This form is intended for the current treating health care provider of a Cornell University employee.

The Cornell Office of Civil Rights (COCR) is requesting your assistance in gathering information to help evaluate a request for workplace accommodations under the Americans with Disabilities Act (ADA) and Cornell University Policy 6.13: "Accommodations for Faculty and Staff."

Your insights will help COCR understand how the employee's condition may impact their ability to perform essential job functions and explore reasonable accommodations to support their success at work.

Section 1: Employee Information

- Employee Name: _____
- Employee Date of Birth: _____

Section 2: Impairment/Disability Determination

1. Does the employee have a physical or mental impairment that affects major life activities or major bodily functions? *(Examples include working, walking, seeing, hearing, speaking, breathing, learning, or performing manual tasks.)*

   ☐ Yes ☐ No

2. If yes, please indicate the type of impairment:

   ☐ Physical ☐ Mental

3. What is the expected duration of the impairment?

   ☐ Temporary: From _____ to _____

   ☐ Permanent

4. Does the impairment substantially limit any major life activities or bodily functions?

   ☐ Yes ☐ No

5. If yes, please specify the affected activities or functions:

   _____

   _____

   _____

   _____

   _____

   _____

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Section 3: Treatment History

1. Please describe the diagnosed medical condition(s) or impairment(s), including the date of onset and any relevant clinical details that help explain the nature and severity of the condition.

2. How long has the employee been receiving treatment for this condition?

3. How frequently is treatment provided? *(e.g., daily, weekly, monthly)*

4. Date of the most recent clinical evaluation: _____

5. Date of the next scheduled evaluation (if applicable): _____

Section 4: Accommodation Information

1. How does the condition affect the employee's daily functioning? Please include symptoms, their severity, and how they impact major life activities or bodily functions.

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2. If the condition is cyclical or episodic, please describe the pattern of symptoms, including frequency, duration, and any known triggers.

3. List any current medical restrictions or functional limitations (e.g., lifting limits, mobility restrictions, cognitive limitations).

4. How might these restrictions interfere with the employee's ability to perform their job duties?

5. Identify specific job tasks or responsibilities that may be affected by the condition or limitations.

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6. What workplace accommodations would you recommend to support the employee?
(Examples: modified schedule, assistive devices, remote work, physical adjustments).

_____

_____

_____

_____

_____

_____

7. How would the recommended accommodations help reduce or eliminate the impact of the impairment?

_____

_____

_____

_____

_____

_____

8. Are the recommended accommodations:

☐ Temporary: From _____ to _____

☐ Permanent

Section 5: Authorization and Submission Instructions

Authorization
By signing below, I confirm that I have reviewed the employee's position description and considered their medical condition and/or functional limitations. Based on this review, I have provided recommendations for accommodations that may support the employee in the workplace.

Health Care Provider Name (Print): _____

Health Care Provider Signature: _____
Date: _____

Submission Instructions
Please submit the completed form using one of the following secure methods:

- Email: accommodations@cornell.edu
- Fax: (607) 255-2242
- Secure File Transfer: Contact COCR via email for instructions.

If you have questions or need assistance, please reach out to COCR:

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Important Note: Submitting this form is part of the interactive process to help determine reasonable accommodations. Each request is reviewed individually, and accommodations are not guaranteed until a formal determination is made by COCR.

Confidentiality Reminder: In accordance with the Genetic Information Nondiscrimination Act of 2008 (GINA), please do not include any genetic information when completing or submitting this form.