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 PWFA 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 Cornell University Policy 6.13: "Accommodations for Faculty and Staff," and the Pregnant Workers Fairness Act (PWFA).

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: Diagnosis and Condition

1. What is the patient's physical or mental condition that is related to, affected by, or arising out of pregnancy, childbirth, or a related medical condition?

   _____

   _____

   _____

   _____

   _____

   _____

2. Is the condition temporary or ongoing?

   _____

   _____

   _____

   _____

   _____

   _____

3. What is the expected duration of the condition?

   _____

   _____

   _____

   _____

   _____

   _____

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Section 2: Functional Limitations and Impact on Work

1. Does the condition result in any physical or mental limitations?

2. Are these limitations expected to change over time?

3. How does the condition affect the patient's ability to perform their job duties?

4. Are there specific tasks, environments, or conditions that should be avoided?

Section 3: Recommended Accommodations

1. What workplace accommodations would support the patient in safely performing their job?

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2. How would the recommended accommodations help mitigate the limitations?

_____

_____

_____

_____

_____

_____

3. Are the recommended accommodations:

☐ Temporary: From _____ to _____

☐ Permanent

Section 4: 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:

- Email: accommodations@cornell.edu
- Phone: (607) 255-2242

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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.