



**Amherst College
Office of Human Resources**

**Medical Information Request Form for Reasonable
Accommodations**

To initiate a request for a reasonable accommodation, an employee must:

- Submit the completed Reasonable Accommodation Request form and the Medical Information Request for Reasonable Accommodations form to the Office of Human Resources.
- The Medical Information Request form is to be completed by the employee’s physician or care provider. Employees are to complete Section I below, provide a copy of their job description to their medical provider and have the medical provider complete Section II. All documents, including the employee’s job description, must be attached to this form.
- Completed forms are to be returned to: Office of Human Resources, Amherst College P.O. Box 5000, Amherst, MA 01002-5000 or faxed to: (413) 542-2687. For questions, please call (413) 542-5403.
- Contents of this request are confidential and will only be shared as needed with the appropriate personnel to consider the implementation of a reasonable accommodation. All medical documentation will be kept confidential.

Section I: To be completed by the employee:

Employee Name

Job Title

Department

Supervisor

Release of Information

I hereby authorize the release of the following information to Amherst College for the purpose of determining the availability of reasonable workplace accommodations. I further authorize Amherst College to seek clarification of this documentation if necessary by contacting my physician or care provider.

Employee Signature

Date

Section II: To be completed by the physician or care provider:

To initiate a request for reasonable accommodations, employees must provide current documentation of a disability. As the employee's physician or care provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary. To complete this form, you should review the employee's job functions and other information relevant to the employee's job at Amherst College. If those materials have not been provided, please contact the employee and let him or her know you cannot complete this form without those materials.

Note: The statutory definition of disability with respect to an individual is "a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or (C) being regarded as having such an impairment".

Employee Name:

1. Please identify the employee's physical or mental impairment:

- Please describe the effects or limitations (e.g. long-term, permanent, recent, short-term).

2. Please describe the effects or limitations this impairment has on the employee's life activities, if any:

3. By reviewing the attached information concerning the employee's job duties, please describe the effect or limitations the impairment has on the employee's ability to perform the job duties, if any. Please be very specific in noting the limitations on specific duties and responsibilities listed.

- Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or other due to the impairment? Please elaborate.

4. Please offer any suggested accommodations that might enable the employee to perform his or her job duties.

5. What is the duration of the accommodations noted?

6. Additional Comments

Thank you for your assistance in providing this information so that we may assess the employee's request. We will contact your if further information is necessary. Please sign below.

Signature of physician or care provider

Date

Physician or care provider name (please print)
Number

Telephone