Healthcare Provider Response
Information for Accommodation Request

Employee Name: _____

Name of Healthcare Provider: _____

Provider Phone and Address: _____

Dear Treating Healthcare Provider:

Our employee requests an accommodation. In order for the University to evaluate the request please complete this form and return it to me at the address listed at the bottom of this page as soon as possible. The employee should have also provided you with a completed *Authorization for Release of Medical Information* completed by our employee for you to return with this form.

Attached is a current copy of the employee's written job description which describe functions of the position of employment for your use in completing this form. Please note that an essential function of all positions of the University is the ability to maintain reliable attendance and punctuality.

Please do not disclose on this form any disabilities that are NOT related to the employee's request for accommodations.

This form is used for accommodation requests by University employees or individuals that have already has been offered employment with the University.

If you have any questions about the form, you may contact me at (408) 554-5750.

Your assistance is greatly appreciated!

Indu Ahluwalia
Senior Benefits Specialist
Department of Human Resources
SANTA CLARA UNIVERSITY
500 El Camino Real
Santa Clara, CA 95053
iahluwalia@scu.edu

Employee Name: _____

For completion by the treating healthcare provider:

1) Based on the employee's records and your medical judgment, does he/she have a physical or mental impairment that will adversely affect a major life activity? If so, please describe with specificity.
_____
_____
_____

2) To what degree and/or at what frequency is the impairment affecting the employee's ability to perform the above noted life activities? In your opinion, how does this compare and/or contrast with an average person in the "general population"? Please be specific. _____
_____
_____

a) For how long a period of time has the employee been impaired in those life activities?
_____

b) For how long a period of time will the employee be impaired in those life activities?
_____

c) Are there any mitigation, assistance or other measures the employee can or does use to offset the effect of the adverse effect on life activities?
_____

3) In your opinion are there any job functions, noted on the attached job description, that the employee is unable to perform as a result of the impairment? Please note that an essential function of all positions of the University is the ability to maintain reliable attendance and punctuality. If yes, please note which specific job functions the employee unable to perform, and for how long they will be unable to perform them, and what potential accommodations, if any, would enable them to perform such function?

a)_____
b)_____
c)_____
d) _____

Employee Name: _____

4) If you identified potential accommodations above, please explain how these accommodations will enable the employee to perform the specific job functions and how long would these potential accommodations need to be in effect?
   a)_____
   b)_____
   c)_____
   d)_____

5) Is there a possibility that our employee will cause a health or safety harm or injury to themselves or other persons in connection with performing job functions, either with or without accommodation(s)? If yes, please explain.
   _____
   _____
   _____
   _____
   _____

☐

Thank you for your assistance. We may contact you for additional information or clarification.

To be completed by the treating healthcare provider:

_____	_____
Print Name	Medical Specialty
_____	_____
Signature	Date