CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO
Human Resources

AMERICANS WITH DISABILITIES ACT (ADA) REQUEST FOR REASONABLE ACCOMMODATION FORM FOR HEALTH CARE PROVIDER/PHYSICIAN

CONFIDENTIAL

To be completed by CSUSB Employee

To (Dr. Name):_____ Medical Office: _____

Patient Name: _____

Patient Home Address: _____

Patient Phone #: _____ Email: _____

Patient Job Title: _____ Department: _____

Patient HIPPA Release Authorization:

I, _____, authorize my physician to answer the medical questions requested on the *Americans with Disabilities Act (ADA) Request for Reasonable Accommodation Form for Health Care Provider/Physician* and release information to California State University, San Bernardino Human Resources Department.

Signature: _____ Date: _____

Your patient has requested that the CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO (CSUSB) provide a reasonable accommodation(s) so that he/she can perform the essential functions of the job he/she has, or is seeking. It is necessary that you provide the following information within fifteen (15) days from the date of receiving this form so that CSUSB can determine whether this person is an individual with a disability as defined by the Americans with Disabilities Act (ADA).

Please return completed form in one of the following methods:

1) Mail

Human Resources Department
5500 University Parkway – SH 110
San Bernardino CA, 92407

2) Fax: 909-537-7019 – (Attention: Human Resources)

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To be completed by Medical Physician.
Please attach additional documentation, if necessary, to respond to the questions listed below.

1) What is the length of time that you have provided treatment to this patient?

2) Please describe in detail your patient's diagnosis as it relates to his/her disability?

3) Please provide specific ICD-9-CM/DRG medical codes.

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4) Please list the your patient's physical and/or mental impairments?

5) Please identify all major life activities (i.e. walking, talking, hearing, speaking, ability to care for self) that are affected or limited by the patient's medical condition or impairment outlined in answer number 4.

6) How does your patient's medical condition or impairment limit his/her ability to perform his/her job function? Please describe in detail.

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7) Are the medical conditions or impairments that you described in answer number 6 permanent? If not, what is the projected duration of the patient's limitations or impairments that will interfere with his/her ability to perform his/her job functions?

8) Please provide names, telephone numbers and/or addresses of any referrals you provided to the patient.

Completed By (Print Name)_____

Position/Title: _____

Medical Office: _____

Contact Number: _____ Email: _____

Signature: _____ Date: _____

For any questions, please contact the Human Resources Department.