CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
DEPARTMENT OF HUMAN RESOURCES

CONFIDENTIAL

AMERICANS WITH DISABILITIES ACT (ADA)
REQUEST FOR REASONABLE ACCOMMODATION

Date: _____

Health Care Provider:

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 thirty (30) days from the date at the top of 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).

Patient's Name:

_____

Last First Middle Initial

_____

Employee Identification Number

Date of Birth:_____

Length of time you have provided treatment to patient:

_____

Please attach additional sheets as necessary to respond to the following.

1. Please detail patient's diagnosis:

_____

_____

_____

2. Provide specific ICD-9-CM/DRG medical codes:

_____

_____

_____

HEALTH CARE PROVIDER CERTIFICATION

3. What are the patient's physical and/or mental impairments?

4. What is the patient's prognosis as to each impairment and/or condition?

5. Identify all major life activities, i.e., walking, talking, hearing, speaking, ability to care for self, etc., that are affected or limited by the patient's medical condition or impairment listed in paragraph 4:

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

7. Are the medical conditions or impairments that you describe in paragraph 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. Provide names, telephone numbers and/or addresses of any referrals you provided to the patient