OFFICE OF EQUAL OPPORTUNITY
COLORADO STATE UNIVERSITY
101 Student Services Building
0160 Campus Delivery
Fort Collins, CO 80523 -0160
(970) 491-5836

Request for Reasonable Accommodation
Health Care Provider Evaluation

To be completed by Health Care Provider Only

Employee Name:_____

The following information is being requested in order to determine if the above employee has a disability as defined by the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA) and is eligible to receive accommodation(s) under the ADA and the ADAAA.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

A. Determination of Disability

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities or has a record of such an impairment. The following questions are to assist in determining whether an employee has a disability.

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

If yes, what is the impairment/diagnosis?_____

Date of diagnosis: _____

Is the impairment permanent? ☐ Yes ☐ No

If not permanent, what is the anticipated duration of the impairment?_____

Answer the following questions based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used.

Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit one or more major life activities? ☐ Yes ☐ No

Note: Does not need to significantly or severely restrict to meet this standard

If yes, what major life activity(s)?

☐ Lifting	☐ Walking	☐ Hearing	☐ Caring for Self
☐ Sleeping	☐ Standing	☐ Seeing	☐ Interacting with others
☐ Concentrating	☐ Reaching	☐ Speaking	☐ Performing manual tasks
☐ Breathing	☐ Thinking	☐ Learning	☐ Communicating
☐ Working	☐ Reading	☐ Sitting	☐ Other:_____
☐ Eating	☐ Bending		

Does the impairment substantially limit operation of one or more major bodily functions? ☐ Yes ☐ No

Note: Does not need to significantly or severely restrict to meet this standard.

If yes, what bodily function(s)?

☐ Immune	☐ Genitourinary	☐ Circulatory	☐ Special sense organs/skin
☐ Hemic	☐ Lymphatic	☐ Endocrine	☐ Normal cell growth
☐ Digestive	☐ Neurological	☐ Reproductive	☐ Other_____
☐ Bowel	☐ Brain	☐ Musculoskeletal	
☐ Bladder	☐ Respiratory	☐ Cardiovascular	

B. Accommodations

How do the employee's limitations impact ability to perform the job? Please be specific and include the severity and frequency of occurrence of the limitations

C. Comments

Provider Signature: _____ Date: _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____