Human Resources
306 S. New St, Suite 437
Bethlehem, PA 18015
Tel: (610) 758-3900 | Fax: (610) 758-6226
Email: inhro@lehigh.edu

Medical Information Request and Verification Form

Dear Physician,

Our employee, _____, has submitted a request for a reasonable accommodation. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise.

Background

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. **"Substantially limits" under the ADAAA has been broadened to allow** someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual *or expected* duration less than or equal to six months.

The ADAAA provides examples of **"major life activities,"** including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

Please review the accompanying Position Description and provide your responses to the following:

Questions to help determine disability and reasonable accommodation			
1. Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?		Yes	No
If *yes*, continue to next question. If *no*, how long will the employee be unable to perform these job duties?			
____ Weeks	____ Months	____ Permanently	
2. Does the employee have a physical or mental impairment?		Yes	No
If *yes*, what is the impairment?			
3. What limitation(s) is interfering with job performance, and how does it interfere with the employee's ability to perform the job function(s)?			

4. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?
5. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?
6. How would these adjustments improve the employee's job performance?
7. How long will the employee need this reasonable accommodation?
8. If unable to provide date, when will he or she be medically reevaluated?
9. Any additional comments or suggestions:

Signature and Contact Information	
Physician Name	Telephone Number
Physician Signature	Date

Please return this form along with any other additional information that might be useful in processing this accommodation to: Linda Lefever | lip3@lehigh.edu

Attachment(s):

- ☐ Position Description
- ☐ Physical/Mental Capacities and Limitations