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BOWLING GREEN STATE UNIVERSITY

MEDICAL INFORMATION REGARDING IMPAIRMENT
FACULTY AND STAFF
HEALTHCARE PROVIDER'S STATEMENT

Patient/Employee Name:_____

Home Address: _____

_____

Telephone: _____

The Bowling Green State University employee named above (your "patient") is requesting an accommodation due to a claimed physical or mental impairment. When considering such accommodation requests, University policy permits an employee's attending health care provider to offer his/her professional opinion regarding the nature and extent of the claimed impairment. To be considered, this *Healthcare Provider's Statement* must be based on clinical information and diagnosis that is current within six (6) months of the date of the accommodation request.

(You may attach additional numbered pages to this form, if necessary, to fully respond to our questions.)

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38 College Park Office Building
Bowling Green, OH 43403-0185

Phone 419-372-8495
Fax 419-372-8496
Email: access@bgsu.edu
www.bgsu.edu

Firelands Campus
105 George Mylander Hall
One University Drive
Huron, OH 44839-9719

Questions for Healthcare Provider:

1. Have you diagnosed the Patient to have:

a mental or psychological disorder; ☐ Yes ☐ No

or

a physical impairment? ☐ Yes ☐ No

If your answer to both questions is in the negative, please do not proceed any further; sign where indicated below, and return this form to the address indicated above.

If you answered "Yes" to either question, what is the nature of each disorder and when was each first diagnosed? *(If there is more than one diagnosed disorder, please label them Condition #1, Condition #2, etc.)*

_____

_____

_____

2. Does the diagnosed condition or conditions described in your answer to question 1 have a limiting effect on the Patient's ability to perform certain major life activity functions such as, caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working?

☐ Yes ☐ No

If your answer is in the negative, please do not proceed any further; sign where indicated below, and return this form to the address indicated above.

If your response is in the affirmative, please list each limiting effect for each diagnosed condition.

_____

_____

_____

3. For each limiting effect dealing with a major life activity listed above in your response to question 2:

(a) Is the Patient unable to perform that activity to the same extent that the average person in the general population can perform the activity?

Condition # 1 _____ Ye☐ No☐

Condition # 2 _____ Ye☐ No☐

(b) Is the Patient "**significantly limited***" as to the condition, manner or duration under which the Patient can perform that major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform the same major life activity?

Condition # 1 _____ Yes☐ No ☐

Explanation _____

Condition # 2 _____ Yes☐ No ☐

Explanation _____

***The following factors should be considered in determining whether an individual is "substantially limited": (1) the nature and severity of the impairment; (2) the duration or expected duration of the impairment; and (3) the permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment.**

(c) To what extent, if any, can the limiting effect of each condition be controlled or eliminated by treatment including, but not limited to, the use of medications, therapies, physical aids, or other types of mitigating measures?

Condition #1 _____

Condition #2 _____

4. If you have listed the major life activity of "working" in your response to question 3 above, is the Patient –

(a) Significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes, as compared to the average person having comparable training, skills, and abilities?

☐ Yes ☐ No

If yes, please explain: _____

_____

Or

(b) Significantly restricted to a geographical area to which the individual has reasonable access?

☐ Yes ☐ No

If yes, please explain: _____

_____

5. Has the patient discussed with you the physical and mental functions required of his/her employment with the University?

☐ Yes ☐ No

6. Did the patient supply you with a Position Description and/or the "Physical and Environmental Job Requirements Analysis" form?

☐ Yes ☐ No

If yes, how does the patient's condition relate to his/her ability to perform those functions?

_____

_____

7. In your opinion, can the patient adequately perform those functions with an accommodation?

☐ Yes ☐ No

If yes, what type of accommodation do you recommend (e.g., auxiliary aids, equipment, work scheduling, etc.)?

_____

_____

ATTESTATION BY HEALTHCARE PROVIDER

By signing where indicated below I am representing to Bowling Green State University that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief, that it constitutes my best professional judgment and opinion, and that the patient did not prepare or draft that response for my signature.

Signature: _____ Date: _____

Printed Name and Professional Status: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Return this information marked confidential to:
Peggy Dennis
Accessibility Services
Bowling Green State University
38 College Park Office Building
Bowling Green, OH 43403

Thank you for completing this form.