

**Medical Information Regarding Impairment  
Faculty and Staff  
HEALTHCARE PROVIDER'S STATEMENT**

Patient/Employee Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone/TDD: \_\_\_\_\_

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 healthcare 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.)*

***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 have 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 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.

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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 \_\_\_\_\_  Yes       No

Condition #2 \_\_\_\_\_  Yes       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 that 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

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?

\_\_\_\_\_  
\_\_\_\_\_

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.)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

