Boston University Occupational Health Center
930 Commonwealth Avenue
Boston MA 02215

Request for Medical Information for ADA Accommodation – Face Covering Adjustment

Employee Name: _____ DOB: _____ Cell Phone: _____
Employee BUID#: _____ Today's Date: _____

Dear Healthcare Provider,
Your patient is employed at Boston University and has requested an accommodation in the workplace from wearing a face covering, required at Boston University due to the COVID-19 pandemic. We require additional specific medical information to be able to review this request. Please provide complete, specific and legible answers to the questions below. Thank you for assisting your patient and Boston University.

ATTENTION Treating Provider: you are required to submit medical records including objective test results and narratives associated with this condition/diagnosis and treatment. YES_____NO_____

I authorize my provider to release the requested information to the Boston University clinician, identified above.
Patient Signature: _____ Date: _____

Health Care Provider: Please complete the information below and return this form to your patient so they may include it in their face covering adjustment request.

☐ **This request for accommodation is related to COVID-19 and face covering/mask use in the workplace.**

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
   a. If yes, what is the impairment or the nature of the impairment? **How does this affect their ability to wear a face covering/mask (please state specifically why they are unable to use a face covering/mask including diagnosis)?**
   _____
   _____
   _____

2. Does the impairment substantially limit a major life activity as compared to most people in the general population?
   ☐ Yes ☐ No
   a. If yes, what major life activity(s) (includes major bodily functions) is/are affected?

☐ Sitting	☐ Caring for Self	☐ Reaching	☐ Speaking	☐ Other: (describe)
☐ Standing	☐ Eating	☐ Bending	☐ Thinking	
☐ Walking	☐ Hearing	☐ Lifting	☐ Learning	
☐ Sleeping	☐ Seeing	☐ Performing Manual Tasks	☐ Reading	
☐ Breathing	☐ Interacting with Others	☐ Working	☐ Concentrating	

   b. Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

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3. In your medical opinion does this employee require consideration of a waiver for wearing a face covering/mask to work on campus? ☐ Yes ☐ No

    a. If yes, is the employee unable to wear a mask at all times, or only under certain conditions/situations/duration of time (please state specifically the conditions/situations/duration of time i.e. 1 hour, which the employee can wear the face covering/mask)? Statement must include how medical condition correlates with employee's inability to wear mask on a full or part-time basis:

_____
_____
_____

4. Is diagnosis permanent or temporary? _____
    a. If temporary please state projected duration of diagnosis/ impairment: _____

_____

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 an individual or family member of the individual, except as specifically allowed by this law. 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.

I hereby acknowledge and verify by my signature that the information provided is accurate, complete, and current.

MD/NP/PA/DO Signature: _____ Date:_____

Print Physician Name: _____

State/License #_____

Address:_____

Phone:_____Fax:_____

Health Care Provider: Please complete the information above and return this form to your patient so they may include it in their face covering adjustment request.