Boston University Equal Opportunity Office
888 Commonwealth Ave., Suite 303
Boston, Massachusetts 02215
T 617-353-6474 F 833-601-0856
www.bu.edu/eoo

BOSTON UNIVERSITY

Request for Information for ADA Reasonable Accommodations

Dear Healthcare Provider**,**

Your patient is employed at Boston University and has requested a reasonable accommodation under the ADA to assist them in performing their job. In order to assess whether we can make an accommodation, we need you to both confirm an accommodation is needed and get your input as to whether the requested accommodation would allow your patient to perform the essential functions of their position. Please complete the below medical questionnaire in full so that we may be able to review this request. Thank you for assisting your patient and Boston University.

Patient Name:
DOB:

Health Care Provider: Please complete the information below and submit this form by FAX to 1-833-601-0856

SECTION ONE: QUESTIONS TO HELP DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
   a. If yes, please describe the nature of such impairment, including whether it is physical or mental.
      _____
      _____
   b. Is the condition likely to get better? ☐ Yes ☐ No
      If so, what is a reasonable estimate of the timeframe?
      _____
      _____
   c. Is the condition likely to get worse? ☐ Yes ☐ No
      If so, what is a reasonable projection of the course of the medical condition?
      _____
      _____
2. Does the impairment substantially limit a major life activity as compared to most people in the general population?
   ☐ Yes ☐ No

SECTION TWO: QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

3. Are there restrictions and/or limitations that affect your patient's work? Please mark all that apply and be as specific as possible (e.g., if providing a restriction to standing, how many minutes can the person stand before they would need to sit for X minutes). **List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them**.
   - ☐ Maximum lifting and/or carrying of _____ pounds. These restrictions apply to ____ right arm, ____ left arm, _____ both arms.
   - ☐ Maximum repetitive lifting/carrying of _____ pounds. These restrictions apply to ____ right arm, ____ left arm, _____ both arms.
   - ☐ No bending more than _____ times in a row and ____ minutes per hour
   - ☐ No stooping more than _____ minutes at one time and _____ minutes per hour

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- ☐ No squatting more than _____ minutes at one time and _____ minutes per hour
- ☐ No kneeling more than _____ minutes at one time and _____ minutes per hour. These restrictions apply to ____ right knee, ____ left knee, _____ both knees.
- ☐ No pushing/pulling of _____ pounds of force
- ☐ No standing in excess of _____ minutes at one time and _____ minutes per hour ____ hours per day
- ☐ No sitting in excess of _____ minutes at one time and _____ minutes per hour ____ hours per day
- ☐ No walking in excess of _____ minutes at one time and _____ minutes per hour ____ hours per day
- ☐ Restricted above shoulder level reach for _____ minutes at one time and _____ minutes per hour. These restrictions apply to ____ right arm, ____ left arm, _____ both arms.
- ☐ Must alternate sitting/standing after ____ minutes of one activity
- ☐ No running or no running more than _____ minutes at one time and maximum minutes per day
- ☐ No jumping
- ☐ No climbing stairs or steps
- ☐ Limit stairs and steps to ____ steps at one time
- ☐ Maximum keyboarding/data entry at one time_____ minutes, ____minutes per hour and _____ hours per day
- ☐ Maximum time between breaks at one time_____ minutes, ____minutes per hour and _____ hours per day
- ☐ After a total of _____ minutes per hour, employee will require a break.
- ☐ After a total of _____ minutes per 8-hour shift, employee will require a break.
- ☐ Additional ____ minutes to perform a task. If a task should take 1 hour, employee will require ____ additional minutes.
- ☐ Avoid specific triggers. Please list triggers and specify whether these triggers should be removed or limited/reduced:

  _____

  _____
- ☐ Adjustments to workspace:
  - Location (please specify): _____
  - Noise level (please specify):_____
  - Lighting (please specify):_____
- ☐ Adjusted work hours (please specify): _____
- ☐ Limited on-campus work:
  - Employee can work on-campus for a total of ____ hours per day
  - Employee can work on-campus for a total of ____ hours per week
  - Employee can work on-campus for a total of ____ hours per month
    - Boston University currently offers qualified employees the opportunity to work remotely two days per week. Will this fulfill this employee's needs? ____ Yes ____ No
- ☐ Other limitations/restrictions (list below):

  _____

  _____

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4. Duration:
   - ☐ Restrictions are **temporary:**
     From (start date): _____ Through (expected end date): _____
   - ☐ Restrictions are **permanent**

a. Date employee can return to work with or without accommodation: _____

SECTION THREE: QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

5. Do you have any suggestions regarding possible accommodations? _____ Yes _____ No
6. If yes, what are your suggestions regarding possible accommodations to assist the employee in performing the essential functions of their job?_____
   _____
   _____
   _____
7. How would your suggestions improve the employee's ability to perform the essential functions of their job? _____
   _____
   _____
   _____

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:_____

Boston University may request additional documentation if the information above is not sufficient to proceed with the reasonable accommodation process. Please respond to all requests in a timely fashion to avoid delays.