Boston University Equal Opportunity Office
888 Commonwealth Ave., Suite 303
Boston, Massachusetts 02215
T 617-358-1796 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 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 QUALIFYING DISABILITY

1. Does the patient have a physical or mental impairment?

☐ Physical	☐ Mental
☐ Both	☐ No impairment

2. Does the impairment substantially limit a major life activity as compared to most people in the general population?
   ☐ Yes ☐ No

3. If yes, what major life activity(s) (including major bodily functions) is/are affected:

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

SECTION TWO: QUESTIONS TO UNDERSTAND LIMITATIONS DUE TO A MEDICAL CONDITION

4. Please mark all limitations that affect your patient's ability to perform the essential functions of their position. **Be as specific as possible.**
   - ☐ Maximum lifting and/or carrying of _____ pounds. These limitations apply to: (circle one) right arm / left arm / both arms
   - ☐ No bending at waist more than _____ times in a row and ____ minutes per hour
   - ☐ No squatting more than _____ minutes at one time and _____ minutes per hour

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- ☐ No kneeling more than _____ minutes at one time and _____ minutes per hour. These limitations apply to: (circle one) right knee / left knee / both knees
- ☐ No pushing/pulling more than _____ pounds of force
- ☐ No standing more than _____ minutes at one time and _____ minutes per hour
- ☐ No sitting more than _____ minutes at one time and _____ minutes per hour
- ☐ No walking more than _____ minutes at one time and _____ minutes per hour
- ☐ Restricted above shoulder level reach for _____ minutes at one time and _____ minutes per hour. These limitations apply to: (circle one) right shoulder / left shoulder / both shoulders
- ☐ Must alternate sitting/standing after _____ minutes
- ☐ Limit stairs to _____ steps at one time
    - In the event of an emergency, can your patient safely and successfully navigate a full staircase?
        - ☐ Yes
        - ☐ No
- ☐ After a total of _____ minutes per hour, employee will require a _____ minute(s) break.
- ☐ Additional time to perform a task. Please specify: _____
- ☐ Computer usage:
    - Maximum keyboard usage at one time: ____minutes per hour and _____ hours per day
    - Maximum screen time: ____minutes per hour and _____ hours per day
- ☐ Due to your patient's condition, adjustments to the workspace may be necessary (e.g. office location, lighting, noise level, work hours). **Please specify the medical limitation that may necessitate any adjustments.** *Please note, our office only requires the medical limitation. If only a recommendation or diagnosis is provided, it will not allow us to properly explore potential accommodations and additional follow up from our office may be needed.*

_____
_____
_____
_____
_____

☐ **Other limitations (list below)** *Please note, our office only requires the medical limitation. If only a recommendation or diagnosis is provided, it will not allow us to properly explore potential accommodations and additional follow up from our office may be needed.*

_____
_____

5. Status of impairment (please provide your best medical judgement):
    - Limitations are:
        - ❒ **Temporary** from (start date): _____ through (expected end date): _____
        - ❒ **Permanent**
    - Date employee can return to work: _____
    - Will patient's condition likely worsen, thereby potentially requiring additional and/or adjusted accommodations? ☐ Yes ☐ No

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SECTION THREE: QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

6. Based on the employee's medical limitations, do you have suggestions regarding possible workplace accommodations to assist the employee in performing the essential functions of their position?

_____

_____

_____

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.

Health Care Provider Signature: _____ **Credentials:** _____

Print Health Care Provider Name: _____ **State/License #** _____

Address: _____

Phone: _____ **Fax:** _____ **Date:** _____

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.

Accommodation Tips for Health Care Providers

Quick Formula

Condition → Symptoms → Limitation → Accommodation

What we need

- ✓ What symptoms is your patient currently experiencing as a direct result of their medical condition?
- ✓ How do your patient's symptoms limit their ability to perform their job duties?
- ✓ How would the requested accommodation(s) assist your patient in performing their essential job duties?

What we don't need

- ✗ Diagnosis alone
- ✗ Medical Records
- ✗ Treatment History
- ✗ List of Recommendations
- ✗ Detailed Test Results

EXAMPLE

Symptoms

- Pain
- Fatigue
- Brain fog
- Reduced stamina
- Difficulty concentrating
- Dizziness
- Limited mobility
- Stress Intolerance
- Light Sensitivity

Limitations

- Concentration & Focus: Difficulty staying attentive, fatigue, or trouble completing tasks
- Physical Tasks: Challenges with lifting, standing, bending, or movement
- Communication: Difficulty participating in meetings, understanding requests, or verbal interactions
- Environment Sensitivity: Sensitivity to noise, light, or temperature
- Stress Tolerance: Symptoms worsened by pressure, multitasking, or fast-paced work environments

Accommodations

- Flexible schedule: Helps manage morning symptoms
- Remote work: Reduces environmental triggers
- Ergonomic chair: Supports back pain
- Reduced lifting: Prevents strain or injury
- Extra breaks: Allows time to rest
- Quiet workspace: Limits noise and overstimulation