



Department of Mental Health and Addiction Services

MEDICAL PROVIDER INFORMATION FORM

For consideration of an Employee's Request for Reasonable Accommodation

Please return to:

Affirmative Action Office Contact person: _____

Phone: 860-262-6883

Fax: 860-262-5197

(if faxing, please call beforehand to ensure receipt and confidentiality)

Connecticut Valley Hospital

Cottage 20 (171 Bow Lane)

Middletown, CT 06457

Date: _____

Employee Name: _____

DMHAS engages in an interactive process with employees seeking reasonable accommodation and requests medical information when appropriate to determine if the employee is a qualified person with a disability under the Americans with Disabilities Act (ADA) or the CT Fair Employment Processes Act (CFEPA).

The following questions are to help determine whether an employee is a qualifying person with a disability under the Americans with Disabilities Act (ADA) or the CT Fair Employment Practices (CFEPA).

- Does the employee have a mental or physical impairment? Yes No
- If yes, please describe how the impairment affects the employee, and what the employee's limitations are when the impairment is active.

- What major life activity(s) and/or major bodily functions is/are affected by the employee's impairment?

Major Life activities:

- | | | | | |
|--|--|-----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Hearing | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Interacting With Others | <input type="checkbox"/> Reading | <input type="checkbox"/> Standing | (describe) |
| <input type="checkbox"/> Caring For Self | <input type="checkbox"/> Learning | <input type="checkbox"/> Seeing | <input type="checkbox"/> Thinking | |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working | |

Major bodily functions:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Digestive | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Special Sense Organs |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hemic | <input type="checkbox"/> Normal Cell Growth | & Skin |
| <input type="checkbox"/> Circulatory | <input type="checkbox"/> Immune | <input type="checkbox"/> Operation of an Organ | <input type="checkbox"/> Other: (describe) |

4. Please describe the severity and anticipated duration of the impairment.

Temporary (explain)

Temporary but will take longer than normal to heal (explain)

Anticipated healing period:

Temporary with residual effects (explain)

Permanent

Chronic (explain)

5. A copy of the employee's job description is enclosed. **Please review highlighted areas on the job description, and describe how the employee's limitation(s) may interfere with his/her ability to perform their job function(s) or access a benefit of employment.**

6. Please provide any suggestions regarding possible accommodations to help the employee perform the elements of their job.

7. Additional comments:

Name of Medical Provider _____ **License #** _____

Address _____ **Phone Number** _____

Medical Professional's Signature

Date

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.