Department of Mental Health and Addiction Services

MEDICAL PROVIDER INFORMATION FORM

For consideration of an Employee's Request for Reasonable Accommodation

Please return to:
Equal Employment Opportunity Office; Contact Person: Enter name here
Phone: 860-262-5862
Fax: 860-262-5197
(If faxing, please call beforehand to ensure receipt and confidentiality)
Connecticut Valley Hospital
171 Bow Lane, Cottage 20
Middletown, CT 06457

Date: Click or tap to enter a date.

Employee Name: Enter name here

DMHAS engages in an interactive process with employees seeking reasonable accommodation and request 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).

1. Does the employee have a mental or physical impairment? Yes ☐ No ☐

2. If yes, please describe how the impairment affects the employee, and what the employee's limitations are when the impairment is active.

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

Major Life Activities

☐ Bending	☐ Hearing	☐ Seeing	☐ Thinking
☐ Breathing	☐ Learning	☐ Sitting	☐ Walking
☐ Caring for self	☐ Lifting	☐ Sleeping	☐ Working
☐ Concentrating	☐ Reaching	☐ Speaking	☐ Performing Manual Tasks
☐ Eating	☐ Reading	☐ Standing	☐ Interacting with Others

☐ Other (please explain):

Major Bodily Functions

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Normal Cell Growth
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Operation of an Organ
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs/Skin
☐ Cardiovascular	☐ Hemic	☐ Reproductive	
☐ Circulatory	☐ Immune	☐ Respiratory	

☐ Other (please explain):

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

☐ Temporary (please explain):

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

Anticipated healing period:

☐ Temporary with residual effects (please explain):

☐ Permanent

☐ Chronic (please 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 form 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.