Fashion Institute of Technology
State University of New York

HEALTHCARE PROVIDER CERTIFICATION

This *Healthcare Provider Certification* should be completed by the FIT employee/applicant and their healthcare provider. If necessary, please attach additional pages to clarify whether the employee/applicant has a qualifying disability and to provide the basis for this request for reasonable accommodation. The information furnished on this form must pertain only to the condition for which the employee/applicant is requesting accommodation under the Americans with Disabilities Act (ADA), as amended.

Part I: To be Completed by the Employee / Applicant

Employee/Applicant Name:

Division / Department:

Job Title:

I authorize my healthcare provider (identified below) to release my protected health information to FIT's Office of Human Resource Management and Labor Relations for the purpose of determining whether a reasonable accommodation under the ADA is warranted.

Employee/Applicant Signature:_____Date:_____

An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. An employee/applicant must be able to perform the essential functions of the job with or without an accommodation, and have the requisite skills, experience, and education, and meet other job-related requirements. The ADA provides examples of "major life activities," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and operation of a major bodily function, such as functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

Part II: Medical Certification - To be Completed by the Healthcare Provider

Instructions to the Healthcare Provider: Attached is a copy of the employee's/applicant's job description. Please review this job description prior to completing this form.

Healthcare Provider Name: _____

Type of Practice/Specialty: _____

Address: _____

Phone Number: _____ Fax Number: _____

Questions to help determine whether an employee/applicant has a qualifying disability:

Employee's / Applicant's Medical Diagnosis:

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

2. If yes, please describe the mental or physical impairment.

3. Is the impairment permanent? Yes ☐ No ☐

4. If not permanent, what is the expected duration of the impairment?

5. Is this a condition which:

a. Requires periodic visits for treatment by a healthcare provider? Yes ☐ No ☐
b. Continues over an extended period of time? Yes ☐ No ☐
c. May cause episodic rather than a continuing period of incapacity? Yes ☐ No ☐

6. Does the impairment affect a major life activity? Yes ☐ No ☐

7. If yes, what major life activity (ies) is/are affected?

Major Life Activity	Required?	Major Life Activity	Required?
Caring for Self	☐	Hearing	☐
Standing	☐	Sleeping	☐
Manual Tasks	☐	Thinking	☐
Working	☐	Sitting	☐
Walking	☐	Lifting	☐
Seeing	☐	Reaching	☐

Speaking	☐	Learning	☐
Toileting	☐	Reproduction	☐
Interacting with Others	☐	Concentrating	☐
Breathing	☐	Other:	☐

8. Does the impairment *substantially* limit the major life activity? Yes ☐ No ☐

9. If yes, which one (s)?

Questions to help determine whether an accommodation is needed:

10. What limitation (s), if any, is interfering or may interfere with the essential function (s) of the employee's/applicant's job?

11. What essential function (s) of the job, if any, is the employee/applicant having difficulty performing or may have difficulty performing because of the limitation (s)?

12. How does the employee's/applicant's limitation (s), if any, interfere with their ability to perform the essential function (s) of the job, if they do?

Questions to help determine effective accommodation options:

13. Do you have any suggestions regarding possible accommodations to facilitate job performance? If so, what are they?

14. Additional Comments:

Signature of Healthcare Provider: _____ Date: _____

License No.: _____