Disability Accommodation Health Care Provider Statement Form

For Completion by Health Care Provider:

Your patient, _____ is requesting an accommodation pertaining to his/her employment responsibilities. The information that you provide will assist Albert Einstein College of Medicine in determining the appropriate services and/or reasonable accommodations, if any, for this employee. Please attach additional sheets to fully answer all applicable sections. All information submitted will be kept confidential to the extent permitted by law.

Albert Einstein College of Medicine encourages you to provide a thorough assessment in relation to your patient's accommodation request. Please provide information and records to the following: VP Human Resources and Diversity Officer Albert Einstein College of Medicine 1300 Morris Park Avenue, Suite 1209 Bronx, New York, 10461 Fax: (718) 430-8542.

Health Care Provider's Name & Address:	Telephone: Fax: Email:
Applicable degrees, area(s) of specialization, board certifications, and/or licenses:	
1. What is the nature, severity and anticipated duration of the individual's impairment?	
2. What activities are limited by the individual's impairment?	
3. What accommodation(s) are needed and for how long?	
4. Are there any alternative reasonable accommodation(s)? Please explain.	
5. To what extent does the individual's impairment pose a direct threat, if any, to the safety of themselves or others?	
Provider's Signature:	Date:

This form should be accompanied by a signed copy of Albert Einstein College of Medicine's disability accommodation health care provider release form. (Form 3 of 3)