Cornell University

Medical Leaves Administration
840 Hanshaw Road, Ithaca, New York 14850

Request for Accommodation Based on Disability – Perceptual Limitations

This request form will not be placed in your employment record file. Medical Information Request & Verification for Employee Requesting Accommodation Under the Americans with Disabilities Act and New York Human Rights Law.

Date: ______________________

SS# or Employee ID# ______________________

Name: ____

Home Address: ____

(Number & Street)

____

(City) (State) (Zip)

I do hereby authorize Cornell University Medical Leaves Administration to communicate both verbally and in writing, if necessary, with the appropriate health care or rehabilitation professionals with regard to a resolution of my request for a disability accommodation. My signature indicates that I am aware of the nature of the information being disclosed and with whom it will be shared.

Your Signature: ____ Date: ________________________________

To Be Completed By Physician or Appropriate Medical Professional

Name of certifying professional: ____ Title: ______________________________

(Please Print)

Certification or License# ____ Tele # ____________________________________

Business Address: ____

(Number &Street)

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(City) (State) (Zip)

_____________________________________ _________________________

(Signature of Physician/Medical Professional) (Date)

Content of this request is confidential and will not be shared by any staff member of Medical Leaves Administration except to consider the implementation of the disability accommodation.

To Be Completed By Physician or Appropriate Medical Professional

Patient's Name: ____ **Date of Birth:** ___________________________________

Please circle the appropriate choice:

Visual Impairment:	Visual Acuity	Left	Right
	Field	Left	Right
Hearing Impairment:	Db Loss*	Left	Right

Comments: ____

Briefly describe the nature and severity of the disability, any effect of prescribed medication for this condition and the impact of the disability on the employee's work responsibilities.

Diagnosis:

Prognosis:

Please indicate suggested accommodation(s) of the disability that will assist the employee in performing the essential functions of his/her work responsibilities.

Please provide any other relevant medical information/tests you have performed that would assist us in determining how to best meet the person's needs.

Is the disability **(Please Circle):** Permanent OR Temporary

If the disability is "temporary", how long is the condition expected to last?

__________________ Days __________________ Weeks ______________________ Months

The information provided is based on an evaluation that I have completed for this individual.

___________________________________ ___________________________

(Signature of Physician/Medical Professional) (Date)

(If required, please use additional sheets for any of the information requested above).

Revised 6/08