Cornell University

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

Request for Accommodation Based on Disability – Physical 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 healthcare or rehabilitation professionals with regard to the resolution of my request for a disability accommodation. My signature indicates that I am aware 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: ____

(Please Print)

Title: ____

Certification or License# ____ Tele #___________________________

Business Address: ____

(Number & Street)

____

(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:** ______________________________

In completing the following, please check and indicate either an "I" for the intermittent or "C" for constant in appropriate space.

1. In an eight hour day, employee can **Stand/Walk**:
   Not at all _______________
   1-3 Hrs. _______________
   3 - 5 Hrs. _______________
   5 - 8 Hrs. _______________
   No Restriction ___________

2. In an eight hour day, employee can **Sit**:
   Not at all _______________
   1-3 Hrs. _______________
   3 - 5 Hrs. _______________
   5 - 8 Hrs. _______________
   No Restriction ___________

3. In an eight hour day, employee can **Drive**:
   Not at all _______________
   1-3 Hrs. _______________
   3 - 5 Hrs. _______________
   5 - 8 Hrs. _______________
   No Restriction ___________

4. In an eight hour day, employee can **Lift**:

Weight	No Restriction	Frequently	Occasional	Not at all
0-10 lbs.				
10-20 lbs.				
20-50 lbs.				
50-100 lbs.				
100 + lbs.				

5. In an eight hour day, employee can **Carry**:

Weight	No Restriction	Frequently	Occasional	Not at all
0-10 lbs.				
10-20 lbs.				
20-50 lbs.				
50-100 lbs.				
100 + lbs.				

6. In an eight hour day, employee is able to:

Movement	No Restriction	Frequently	Occasional	Not at all
Bend				
Squat				
Climb				
Kneel				
Twist				

Push/Pull				
Reach				

7. Employee can **use left hand** for:
   Grasp
   "Yes" "No"
   ☐ ☐
   Fine manipulation:
   "Yes" "No"
   ☐ ☐
8. Employee can **use right hand** for:
   Grasp
   "Yes" "No"
   ☐ ☐
   Fine manipulation:
   "Yes" "No"
   ☐ ☐
9. Employee can **use feet** for operation of foot controls:
   "Yes" "No"
   ☐ ☐

10. Employee may perform **sedentary work**:

a) Activities as lifting 10 lbs. (maximum), occasionally lifting or carrying articles like dockets, ledgers and small tools and works that involve some sitting, walking or standing as necessary to carry out duties.
   "Yes" "No"
   ☐ ☐

b) **"Light Work"** (lifting 20 lbs., carrying objects weighing up to 10 lbs., performing a job that involves sitting for longer period of time and/or with a degree of pushing, pulling or arm and leg control)
   "Yes" "No"
   ☐ ☐

c) **"Medium Work"** (lifting 50 lbs., maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)
   "Yes" "No"
   ☐ ☐

d) **"Heavy Work"** (lifting 100 lbs., maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs.)
   "Yes" "No"
   ☐ ☐

e) **"Very Heavy Work"** (lifting in excess of 100lbs., with frequent lifting and/or carrying objects weighing 50 lbs. or more)
   "Yes" "No"
   ☐ ☐

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 employee.

____ ______________________________

(Signature of Physician/Medical Professional) (Date)

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

Last Updated 6/08