



Cornell University

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

Request for Accommodation Based on Disability – Psychiatric Disability

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 the 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)

(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:** \_\_\_\_\_

Briefly describe the nature and severity of the disability:

What would be the effect of prescribed medication for this condition?

Please describe 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