COMMUNITY COLLEGE
OF RHODE ISLAND
Office of Human Resources

DISABILITY VERIFICATION FORM – HEALTH PROVIDER STATEMENT

The employee indicated below has declared a disability and requested a reasonable accommodation in the workplace under the provisions of the American With Disabilities Act (ADA). The attached form is to be completed by the health care provider and should be submitted to the Office of Human Resources with the employee's Reasonable Accommodation Request Form. The information sought is job-related and consistent with business necessity for the following reasons:

- to determine if the individual meets the ADA definition of "individual with a disability";
- to determine if the individual is a qualified person under the ADA, meaning he or she can perform the essential functions of the job currently held (or held before the injury or illness), with or without reasonable accommodation, and without posing a "direct threat" to health and safety of self or others that cannot be reduced or eliminated by reasonable accommoda-tion; and
- to identify an effective reasonable accommodation that would enable the individual to perform essential job functions in the current (or previous) job, or in a current vacant job for which the person is qualified (with or without accommodation).

  The responsibility of making employment decisions or deciding whether or not it is possible to make a reasonable accommodation for a person with a disability lies with officials of the Community College of Rhode Island, not the health care provider.

Medical Authorization (to be completed by the employee)

I,___________________________, do hereby authorize my health care provider to furnish the Community College of Rhode Island (hereinafter CCRI), 400 East Avenue, Warwick, Rhode Island 02886-1807, all medical information pertaining to my request for reasonable accommodation(s).

Signature: ____ Date: _____________________________

1. Employee Name ______________________________ 3. Date _______________

2. Job Title ________________________________4. Dept.______________________

(This Section to be completed by the Health Care Provider)

5. Please describe the employee's current health condition/disability:

6. Date condition/disability commenced _____________________________________

7. Probable duration of condition/disability __________________________________

8. Does the employee's medical condition result in a physical or mental impairment that substantially limits one or more "major life activities"? Yes _____ No _____

   If "yes" please describe the functional limitations; indicating which "major life activities" are affected:

9. Attached is a job description or information about the essential functions of the employee's position. Please circle any items listed on the job description that the employee may not be able to perform based on the employee's medical history and physical exam. Please indicate your opinion by selecting one of the following options:

   _______ Should be able to perform the essential job functions without accommodation;

   _______ May not be able to perform the essential job functions circled on the attached job description and a reasonable accommodation is not feasible;

   _______May not be able to perform the essential job functions circled on the attached job description; however, the following reasonable accommodation(s) should be considered to help the individual perform the essential functions (please list your recommendation for reasonable accommodation):

10. (Optional) If necessary for the protection of the health and safety of this employee or others, please indicate special instructions for first-aid providers or supervisors:

______________________________________	______________________________
(Signature of Health Care Provider)	(Date)
______________________________________	______________________________
(Print Name of Health Care Provider)	(Type of Practice)
______________________________________	______________________________
(Address)	(Telephone Number)