



HARVARD
 LONGWOOD CAMPUS
 HUMAN RESOURCES

To Whom It May Concern,

In order to facilitate the interactive process between employees, Human Resources and their managers, Human Resources explores possible coverage of reasonable accommodations (RA) under the Americans with Disabilities Act. Ms./Mr. _____ (employee inserts) has submitted a reasonable accommodation request for _____ (employee inserts).

Your completion of the brief form below will assist the University's efforts to explore possible reasonable accommodations.

Thank you in advance for your assistance and a copy of the **Job Description** has been given to the employee for you to review.

.....

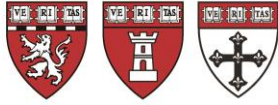
.... Name of Health Care Provider (please print) _____

Signature of Health Care Provider _____ Date _____

State License number _____

1. Does your patient have a physical or mental impairment? Yes ___ No ___
2. If no, please return this form to HR via **fax to 617-432-5005**. If yes, please identify the physical or mental condition(s) below.
3. Does the identified physical or mental impairment(s) *substantially limit* her/his ability to perform a major life activity when compared to the average person in the general population? Yes_ No___ If no, please return this form to **Human Resources via fax to 617-432-5005**. If yes, please check all relevant major life activities(s).

<input type="checkbox"/>	Bending	<input type="checkbox"/>	Seeing	<input type="checkbox"/>	Sleeping
<input type="checkbox"/>	Communicating	<input type="checkbox"/>	Standing	<input type="checkbox"/>	Concentrating
<input type="checkbox"/>	Eating	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Learning
<input type="checkbox"/>	Reading	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Breathing
<input type="checkbox"/>	Speaking	<input type="checkbox"/>	Thinking	<input type="checkbox"/>	Walking
<input type="checkbox"/>	Lifting	<input type="checkbox"/>	Caring for oneself	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Performing manual tasks	<input type="checkbox"/>	Interacting w/ others	<input type="checkbox"/>	



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4. In your opinion, does your patient have a physical or mental impairment(s) manifest in her/his ability to perform her/his essential job functions and physical demands of the position- _____(employee inserts)? Yes__ or No_____
5. For Reduced Schedules or Extended Leave of Absence, what is the duration?

If applicable, please suggest additional workplace modifications, auxiliary aids or services that are necessary to enable him/her to perform the essential functions of his/her job.

Please note reasonable accommodations in the workplace are not granted on the basis of a diagnostic label, alone. A link must be established between the requested accommodations and the current functional limitations of the individual which are pertinent to the essential job functions and demands. Reasonable accommodations must be necessary and must not interfere with business necessity or create an undue administrative burden.

Upon completion, return to me via **fax or email**.

Thank You,
Antonia Gonzalez



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