**Employee Disability Accommodation Medical Inquiry Form**

*Please complete the shaded area prior to giving form to a medical professional, facility or other appropriate provider. Provide a copy of your job description for reference. Return this form to the appropriate Human Resources office. Do NOT return to your Supervisor.*

**Employee / Requestor Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>SBU ID#:</th>
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<tbody>
<tr>
<td>Department:</td>
<td>Supervisor:</td>
</tr>
<tr>
<td>Home Address:</td>
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<tr>
<td>Work Phone:</td>
<td>Home Phone:</td>
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<td>Email:</td>
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I hereby authorize the below referenced health care provider, facility or other appropriate professional to disclose to Stony Brook University Hospital any information about my medical, physical or mental condition for the purpose of providing evidence related to my application for reasonable disability accommodation under applicable state and federal laws.

**Signature:** ___________________________ **Date:** __________

**Authorized Health Care Provider, Facility or Other Appropriate Professional**

**Name(s) (please include all individuals / facilities authorized):**

**Admission/Treatments Date(s):** ___________________________ **Discharge Date(s):** ___________________________

To be completed by health care provider, facility or other appropriate professional.

**Provider, Facility or Other Appropriate Professional Contact Information**

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<tr>
<th>Address:</th>
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<tbody>
<tr>
<td>Phone:</td>
<td>Fax:</td>
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<td>Email:</td>
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**Disability Definition:** For reasonable accommodation under the ADA and the NYS Human Rights Law, an individual has a disability if he or she has a medical, physical or mental impairment that substantially limits one or more major life activities or a record of such an impairment.

**Important Instructions for Professional Individual(s) Completing this Form:**

1. Under the ADA, Stony Brook University may only require necessary medical documentation. Please complete the sections of page 2 of this form necessary to document the disability accommodation request. Please leave blank any sections of this form that are not necessary to documenting the underlying disability or the recommended accommodation.

2. The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of an individuals, except where specifically allowed by law. Please do not include any genetic information, including family medical history, when completing this form.

**Identification of Impairment:**

Does the individual have a medical, physical or mental impairment?  
If yes, what is the impairment or the nature of the impairment?  

☐ YES ☐ NO
INFORMATION REGARDING IMPAIRMENT: (Complete ONLY AS NECESSARY to document Impairment):

Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population?

Describe the individual’s limitations when the impairment is active?

☐ YES  ☐ NO

If yes, what major life activity(s) is/are affected?

IMPACT ON JOB FUNCTIONALITY OR ACCESSING EMPLOYMENT BENEFITS

Taking into account your review of this patient’s job description or performance plan what job function(s) or benefits of employment is the individual having trouble performing or accessing because of the impairment?

How does the individual’s impairment(s) interfere with his or her ability to perform the job function(s) or access a benefit of employment?

RECOMMENDED ACCOMMODATION  ☐

I have reviewed this patient’s job description and or performance program. Based upon your review of the patient’s job description or performance plan, please include here any suggestions you may have regarding possible accommodations that might improve job performance or access?

How could these suggestions improve performance or ability to access job benefits?

Please indicate recommendation duration for accommodation:

Other Questions or Comments – Please feel free to attach additional sheets.

Medical Professional’s Signature

Date

EMPLOYEES - Please indicate which office should receive this form. Do not return this form to the employee’s supervisor.

SBU WEST CAMPUS, RF & HSC EMPLOYEES
Human Resource Services
Attn: Paulene Toissant
(631) 632-6161 Ph • (631) 632-6208 Fax hrs_benefits@stonybrook.edu

STONY BROOK MEDICINE EMPLOYEES
Human Resources
Attn: Tami Goldberg
(631) 444-4734 Ph • (641) 444-4724 Fax tami.goldberg@stonybrook.edu

LISVH EMPLOYEES
LISVH Human Resources
Attn: Denise Muscarella
(631) 444-8617 Ph • (631) 444-8517 Fax denise.muscarella@stonybrook.edu

Marjolie Leonard, ADA Coordinator

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