

Massachusetts Institute of Technology
Human Resources Office of Disability Services
77 Massachusetts Avenue, E19-215
Cambridge, MA 02139
Phone: 617.253.4572
Confidential Fax: 617.253.1502
TTY: 617.258.9344

Accommodation Request Medical Statement

Employee Name: _____

Date: _____

We are requesting medical information (diagnosis and prognosis) which could be used to help determine: 1) whether the employee meets the criteria for an individual with a disability under the Americans with Disabilities Act of 1990, and 2) any reasonable accommodation which might enable the employee to fulfill the essential function of his/her job.

Please provide the following information:

1. Does the employee have a physical or mental impairment? Yes No

2. What is the impairment? _____

3. Is the impairment long-term or permanent? Yes No

4. If not permanent, how long will the impairment likely last? _____

5. Does the impairment affect a major life activity? Yes No

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

- | | | | | |
|--|------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Walking | <input type="checkbox"/> Hearing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Interacting With Others | <input type="checkbox"/> Standing | <input type="checkbox"/> Seeing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Concentrating | |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Thinking | <input type="checkbox"/> Learning | <input type="checkbox"/> Reproduction | |
| <input type="checkbox"/> Working | <input type="checkbox"/> Toileting | <input type="checkbox"/> Sitting | | |

7. Is the employee substantially limited in one or more of these major life activities? Yes No

8. What limitation(s) is interfering with job performance?

9. What job function(s) is the employee having trouble performing because of the limitation(s)?

10. How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

11. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

12. How would your suggestions improve the employee's job performance?

As the employee's request for an accommodation is being evaluated, we may need you to provide us with more detailed information. Should this further information become necessary, you will be provided with a follow-up request specifying any additional information we will need from you.

Medical Professional's Signature: _____

Print Name: _____ Phone Number: _____

Date: _____

Thank you for your assistance.