

Provider Name (please print): _____

Type of Practice / Medical Specialty: _____

Business Address: _____

Phone: _____ Fax: _____

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

If yes, what is the nature and severity of the impairment?

2. What is the prognosis as to the duration of the condition?

3. Does the impairment substantially limit a major life activity? Yes No

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

(examples: speaking, hearing, seeing, breathing, walking, standing, sitting, sleeping, reaching, learning, concentrating, thinking, reproducing, care for self, interacting with others, performing manual tasks)

4. Does the impairment substantially limit a major bodily function? Yes No

If yes, what major bodily function(s) is/are limited? _____

(examples: circulatory, endocrine, reproduction, hemic, special sense organs and skin, lymphatic, immune, normal cell growth, digestive, neurological brain, respiratory, bowel, bladder, genitourinary, musculoskeletal, cardiovascular)

5. What are the limitations/restrictions caused by the condition and/or the treatment of the condition?

6. Please indicate how the condition impacts the employee's ability to perform the essential job functions, and how long you anticipate the condition will last. (see attached)

Essential Job Function	Limitation/Impact	Anticipated Duration
1.		
2.		
3.		
4.		
5.		
6.		

7. What accommodation, if any, do you believe will enable the employee to perform the essential functions of the job?

Signature of Medical Provider

Date

When form is complete, please either: Mail to Dickinson College, Human Resource Services, P.O. Box 1773, Carlisle PA 17013-2896;
Fax to (717) 245-1785; or Email to mould@dickinson.edu

If you have questions, please contact: (717) 245-1503 or HRServices@dickinson.edu