



New Paltz
STATE UNIVERSITY OF NEW YORK

Human Resources • Haggerty 603 • 845-257-3171
Confidential Fax: 845-257-3621

**AMERICAN DISABILITY ACT (ADA)
ACCOMMODATION
MEDICAL FORM**

This form is to be used to make a request for reasonable accommodation of a physical or mental disability as outlined in the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and other pertinent state and local laws. This form is to be used by employees of the College only.

Employee Information

Employee Name _____

Title/Department _____

Bargaining Unit _____

Contact Phone number _____

Personal email _____

By completing this form, I am acknowledging that I am aware that the college engages in an interactive process to identify reasonable accommodations and that the information provided below is part of an ongoing conversation with the College. I hereby release the following information to my employer, SUNY New Paltz.

Signature: _____ Date: _____

Medical Information (to be completed by the employee's healthcare provider)

Healthcare Provider Name _____

Healthcare Provider Address _____

Date of most recent treatment or office visit _____

Brief Diagnosis statement:

Do you certify that the employee is disabled? (Please check one)

Yes No If yes, please explain how the employee's disability might impact their ability to perform their role based on the provided job description.

Do you certify that an accommodation would allow the employee to perform the essential functions of their role?

(Please check one) Yes No

If yes, what accommodations do you believe would help the employee successfully perform their role based on the provided job description? Please include any specific items or devices.

Can the employee work without these accommodations? Yes No

If no, what are the dates the employee is unable to work? From _____ to _____

Is the accommodation temporary? Yes No

If the accommodation is temporary, what are the estimated dates of the accommodation?

From _____ to _____

Signature of Healthcare Provider _____

Date _____

You can return this form to the SUNY New Paltz benefits team via confidential fax at 845-257-3621; by email to benefits@newpaltz.edu; or you may hand-deliver it to the office of Human Resources, Diversity & Inclusion in Haggerty 603.

The information provided in this form is protected under the Genetic Information Nondiscrimination Act (GINA), which prohibits discrimination in accessing benefits or employment based on an individual's disclosure of genetic information. All information received pertaining to your request is kept confidential. This information is maintained separately from personnel records and may only be used in connection with the College's Affirmative Action efforts.