REASONABLE ACCOMMODATION MEDICAL AUTHORIZATION FORM

To Rhode Island School of Design (RISD) Employee:

To complete a request for a reasonable accommodation, an employee must follow directions below:

- The Medical Authorization Form is to be completed by the employee's physician or medical provider. Employees are to complete Section I below, provide a copy of their current job description to their medical provider and have the medical provider complete Section II. The Medical Authorization Form and job description must be attached together.
- Completed form is to be returned to: Human Resources, Attn: Benefit Partner, 20 Washington Place, Providence, RI 02903 or faxed to: (401) 454-6565 or by email to humres@risd.edu. For questions, please call (401) 454-6428.
- Contents of this request are confidential and will only be shared as needed with the appropriate personnel to consider the implementation of a reasonable accommodation. All medical documentation will be kept confidential.

Section I: To be completed by employee: RISD ID: _____

Employee name _____ Job Title _____

Department _____ Supervisor _____

Release of Information

I hereby authorize the release of the following information to RISD's Human Resources Office for the purpose of determining the availability of reasonable workplace accommodations. I further authorize RISD to seek clarification of this documentation if necessary, by contacting my physician or care provider.

Employee signature _____ Date _____

Section II: To be completed by the physician or care provider:

To Physician or Care Provider:

To initiate a request for reasonable accommodations, employees must provide current documentation of a disability. As the employee's physician or medical provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary. Note: Federal and state law define a disability as a physical or mental impairment that substantially limits one or more major life activities, an individual having a record of such an impairment, or an individual being regarded as having such an impairment.

To complete this form, you should review the employee's essential job functions and other information relevant to the employee's job at RISD. If those materials have not been provided, please contact the employee, and let them know you cannot complete this form without those materials. Thank you for your assistance.

Section II Continued:

Employee Name _____

Answer the following question based on what limitations the employee has when their 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

1. **Please identify the employee's physical or mental impairment:**

_____
_____
_____
_____
_____

- Please describe the effects or limitations (e.g. long-term, permanent, recent, short-term).

_____

2. **Does the impairment substantially limit a major life activity as compared to most people in the general population? If yes, describe the employee's limitations when the impairment is active.**
YES ☐ NO ☐

_____
_____
_____
_____
_____

If *yes*, what major life activity(s) (includes major bodily functions) is/are affected?

- ☐ Bending
- ☐ Breathing
- ☐ Caring for Self
- ☐ Concentrating
- ☐ Eating
- ☐ Hearing
- ☐ Interacting with Others
- ☐ Learning
- ☐ Lifting
- ☐ Performing Manual Tasks
- ☐ Reaching
- ☐ Reading
- ☐ Seeing
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Walking
- ☐ Working
- ☐ Other: (describe)

Major bodily functions:

- ☐ Bladder
- ☐ Bowel
- ☐ Brain
- ☐ Cardiovascular
- ☐ Circulatory
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinary
- ☐ Hemic
- ☐ Immune
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Neurological Normal
- ☐ Cell Growth
- ☐ Operation of an Organ
- ☐ Reproductive
- ☐ Respiratory
- ☐ Special Sense Organs & Skin
- ☐ Other: (describe)

3. **By reviewing the job description concerning the employee's essential job functions, please describe the effect or limitations the impairment has on the employee's ability to perform the job duties, if any:**

_____
_____
_____
_____
_____
_____

- Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or other due to the impairment?

_____
_____
_____
_____
_____
_____

_____

4. **Please offer any suggested accommodations, including duration if applicable, that might enable the employee to perform their job duties:**

☐ _____
_____ Duration?_____

☐ _____
_____ Duration?_____

☐ _____
_____ Duration?_____

☐ _____
_____ Duration?_____

Thank you for your assistance in providing this information so that we may assess the employee's request. Please sign below.

_____ _____
Signature of physician or care provider Date

_____ _____
Provider name (please print) Telephone Number