Disability Accommodation Request:

Health Care Provider Form

TO BE COMPLETED BY THE WPI EMPLOYEE:

I hereby request that the health care provider named below complete this form and provide supporting medical documentation for my disability accommodation request to my employer, Worcester Polytechnic Institute (WPI).

I hereby authorize my health care provider to consult with WPI's Division of Talent & Inclusion for WPI to verify my disability, to seek clarification regarding any workplace limitations resulting from my condition(s), and to assist in the exploration of possible reasonable accommodations.

I understand that I may also be required by my health care provider to sign a HIPAA form to release medical information to WPI. I will authorize the release of my medical information to WPI for purposes of my disability accommodation request.

WPI Employee Name:

Home Phone Number:

Home Email:

Work Phone Number:

Work Email:

Brief description of the employee's requested workplace accommodation:

Signature of WPI Employee: Date:

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TO BE COMPLETED BY THE EMPLOYEE'S HEALTH CARE PROVIDER:

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The above-named employee has requested a workplace accommodation from Worcester Polytechnic Institute (WPI) pursuant to the Americans with Disabilities Act and the ADA Amendments Act, the Pregnant Workers Fairness Act of 2017, and applicable Massachusetts and federal laws.

Please complete the following Health Care Provider form, which will be reviewed by WPI's Division of Talent & Inclusion in evaluating the employee's disability and determining the reasonable workplace accommodation(s) for the employee.

Please identify the employee's disability.

Please identify the expected duration of the employee's condition listed above. Due to the condition, if is medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last. Over the next 6 months, episodes of incapacity are estimated to occur how many times per (day / week /month) and are likely to last approximately (hours / days) per episode.

Is the employee under your care for the condition above? If yes, how long?

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Does the employee's condition listed above affect their ability to perform any major life activities?
☐ Yes ☐ No

If yes, describe how:

How does the employee's condition listed above affect the employee's ability to perform the essential duties of their job at WPI? (Job Description Attached)

List the workplace accommodation(s) you believe are necessary as their treating physician:

Health Care Provider Name (please print):

Medical or Other Speciality:

Address:

Phone:

Email:

Signed: Date:

Please email completed form and any related documentation to talent@wpi.edu.