Office of Equal Opportunity

Accommodation Authorization for Release of Medical Information

TO:

____
Printed Name of Medical Provider

____
Address

____
City State Zip Code Telephone Number

RE:

______________________________ ________________
Name of Patient Date of Birth

____
Address

____
City State Zip Code

____
Home Telephone Number

I, ____ authorize my Medical Provider to disclose to my employer, **Tufts University**, Office of Equal Opportunity, the requested information concerning my medical condition to be used solely for the purpose of evaluating my request for a reasonable accommodation under the Americans with Disabilities Act (ADA). This letter further authorizes OEO to speak to my treating physician or health care provider directly in regards to any questions they may have with respect to my condition that relates to the performance of the essential functions of my job and any accommodations which may be necessary.

I understand the requested data is for the above-mentioned purposes and I may refuse to provide the requested medical information. However, I also understand that if I refuse to provide the information, my employer may refuse to provide reasonable accommodation.

____________________________________ ________________
Patient Signature/Tufts University Employee Date

196 Boston Avenue, 4th floor, Medford, MA 02155 |Tel: 617.627.3298| FAX: 617.627.3150|WEB: oeo.tufts.edu

Office of Equal Opportunity

Attention Medical Practitioner:

The staff/faculty member named below has indicated they have a disability and will require reasonable accommodation(s) for the purposes of employment or to participate in a program or activity at Tufts University. In order for Tufts to proceed, we require additional information about the employee's medical condition. We are enclosing with this a medical form (Accommodation Authorization for Release of Medical Information) so the employee is fully informed of what we are asking and can approve the release of the information needed.

The American with Disabilities Act (ADA) requires employers to provide reasonable accommodations to employees who are disabled, i.e., have a medical condition that substantially limits a major life function. We are requesting the following information to determine if the employee is covered under the ADA, and if so, an explanation of the nature of the condition specific to which major life activities the condition limits. In addition, please advise us regarding what accommodations you believe the employee needs in order to perform their job duties and responsibilities. It may be helpful for you to ask the employee's about their job responsibilities and/or job description, and have them make known to you any accommodations they are seeking.

Please return the completed signed forms or send them by fax (please adhere to HIPAA regulations and call before faxing) to Tufts University, Office of Equal Opportunity, at the following address/fax number:

Tufts University
Office of Equal Opportunity
196 Boston Avenue, Suite 4000B
Medford, MA 02155
Fax: 617.627.3075   Phone: 617.627.3298

If you have any questions or concerns about this form, please contact the Tufts Accommodations Team at Accommodations.OEO@tufts.edu.

1. **Patient Name:** ____

2. **Nature of patient's condition(s):** ______________________________________

   ____

3. **Date of onset of condition(s):** ____

4. **Current status of condition(s): (e.g. Active, Progressing, Controlled, In Remission):** ____

   ____

5. **How long is this condition(s) likely to exist (be as specific as possible: e.g., lifetime, one year; six months; one month):** ___________________________

   ____

6. **Does the condition(s) affect a major life activity? Yes [ ] No [ ]**

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

[ ] Caring for Self	**[ ] Walking**	**[ ] Hearing**	**[ ] Standing**
[ ] Seeing	**[ ] Sleeping**	**[ ] Reaching**	**[ ] Speaking**
[ ] Breathing	**[ ] Toileting**	**[ ] Learning**	**[ ] Working**
[ ] Lifting	**[ ] Reproduction**	**[ ] Concentrating**	
[ ] Performing Manual Tasks		**[ ] Interacting with Others**	

   [ ] Other: (describe): ____

   Is the employee substantially limited in one or more of these major life areas?
   Yes [ ] No [ ]

7. **What limitation(s) is/are interfering with job performance?** ________________

   ____

   ____

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

   ____

   ____

   ____

9. **How does the employee's limitation(s) interfere with their ability to perform the job function(s)?**

____

____

____

____

10. **Please state any possible reasonable accommodations you believe are necessary in order for the employee to perform the essential functions of their job.**

____

____

____

____

11. **How would these accommodation recommendations improve the employee's ability to perform their job functions?**

____

____

____

Printed Name of Medical Professional:______________________________

License #:______________________ **State:**______________________

____
Address:

____
City, State, Zip

____
Telephone **Fax**

____
Signature **Date:**

Please return completed form to Tufts University Office of Equal Opportunity
Confidential Fax: 617.627.3075
Email: Accommodations.OEO@tufts.edu
Mail: 196 Boston Avenue, Suite 4000B, Medford, MA 02155