



Smith College Request For Health Information

Patient's Name:		Last Four of Social Security Number	
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Part A: Instructions

The individual listed above is an employee or applicant of Smith College and has submitted a request for a job-related accommodation arising out of a self-reported health condition. The College requires additional information in order to assess whether the patient requires an accommodation(s) to perform one or more essential functions of their job, and if so, identify what accommodations might be effective and reasonable.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. To comply with this law, please do not provide any genetic information when responding to this request for health information. For Smith College to assess the patient's request, please complete the following information and return it to:

Amy Smith, *Human Resources Specialist, Integrated Leaves & Benefits*
Office of Human Resources
Smith College
Fax: 413-585-2284
Email: asmith13@smith.edu
Phone: 413-585-2289

If you have any questions relating to the completion of this form or need clarification of any of the information requested, please contact Amy Smith using the information above. If additional space is necessary, please feel free to attach additional sheets. Thank you for your cooperation and assistance.

Part B: Requested Information

Attached to this form is a job description of the patient's current position at Smith College. After reviewing this description and evaluating the patient, please answer the following questions.

1. Is the patient currently able to perform all of the functions of the position?

- Yes
- No

2. If the answer to Question 1 is "no," please identify the specific function(s) of the position that the employee is unable to perform.

3. Please describe the diagnosis and/or condition that precludes or impairs the patient's ability to perform the specific job function(s) identified in response to Question 2.

3a. For each diagnosis or condition identified in Question 3 above, describe in detail the extent of the patient's limitations or job restrictions and state the known or expected duration of the job restrictions (e.g., patient's 40-pound lifting restriction is permanent; patient cannot work more than 4 hours per day for two weeks; patient cannot drive for 3 months, etc.).

3b. For each limitation or job restriction described in Question 3(a) above, describe the activities that the patient can perform within the restriction (e.g., although the patient cannot lift over 40 pounds, she can lift 10 pounds frequently and 25 to 40 pounds occasionally).

4. Questions 1 through 3 above focus on the patient's ability to work. Do any of the diagnoses or conditions identified in response to Question 3 substantially limit the patient's ability to perform any major life activities other than working, such as caring for themselves, performing manual tasks, walking, seeing, hearing, speaking, breathing, reproducing, learning, etc.?

- Yes
- No

5. If the answer to Question 4 is "yes," please identify all of the major life activities affected by the diagnosis or condition and describe the manner in which the diagnosis or condition limits each activity.

6. In the space provided below, please identify any tests or other diagnostic tools that were used to determine this patient's abilities or the nature of the disability, including the names of the tests or diagnostic tools and the dates on which any such tests or tools were administered to the patient.

Part C: Health Care Provider's Information

Health Care Provider's Name (print):	
Health Care Provider's Practice (print)	
Address:	
Telephone Number:	
Telephone Number:	