Healthcare Provider Response
Information for Accommodation Request

Employee Name: ____

Name of Healthcare Provider: ____

Provider Phone and Address: ____

Dear Treating Healthcare Provider:

Our employee requests an accommodation. In order for the University to evaluate the request please complete this form and return it to me at the address listed at the bottom of this page as soon as possible. The employee should have also provided you with a completed *Authorization for Release of Medical Information* completed by our employee for you to return with this form.

position of employment for your use in completing this form. Please note that an essential function of all positions of the University is the ability to maintain reliable attendance and punctuality.

accommodations.

This form is used for accommodation requests by University employees or individuals that have already has been offered employment with the University.

If you have any questions about the form, you may contact me at (408) 554-5750.

Your assistance is greatly appreciated!

Indu Ahluwalia
Senior Benefits Specialist
Department of Human Resources
SANTA CLARA UNIVERSITY
500 El Camino Real
Santa Clara, CA 95053
iahluwalia@scu.edu

Employee Name: ____

For completion by the treating healthcare provider:

Employee Name: ____

4) If you identified potential accommodations above, please explain how these accommodations will enable the employee to perform the specific job functions and how long would these potential accommodations need to be in effect?
a)____
b)____
c)____
d)____

5) Is there a possibility that our employee will cause a health or safety harm or injury to themselves or other persons in connection with performing job functions, either with or without accommodation(s)? If yes, please explain.
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Thank you for your assistance. We may contact you for additional information or clarification.

To be completed by the treating healthcare provider:

______________________	______________________
Print Name	Medical Specialty
______________________	______________________
Signature	Date