YESHIVA UNIVERSITY
DISABILITY ACCOMMODATIONS
HEALTH CARE PROVIDER STATEMENT FORM

For Completion by Health Care Provider. Your patient _____ is requesting an accommodation pertaining to his/her employment responsibilities. The information that you provide will assist Yeshiva University in determining the appropriate services and/or reasonable accommodations, if any, for this employee. Please attach additional sheets to fully answer all applicable sections. All information submitted will be kept confidential to the extent permitted by law.	
Health Care Provider's Name & Address:	**Telephone #:**
List information pertaining to all applicable degrees, area(s) of specialization, board certifications, and/or licenses:	

The University encourages you to provide a thorough assessment in relation to your patient's accommodation request. Please provide information and records to the following:

a) The identification and evaluation of the nature, severity and duration of the individual's impairment;

b) The identification of the activity or activities that are limited by the individual's impairment;

c) An evaluation of the extent to which the individual's impairment limits their ability to perform the activity or activities identified in Paragraph (b) above;

d) An evaluation of the need for the requested reasonable accommodation(s);

e) An evaluation of the way in which the reasonable accommodation(s) requested by the individual would enable them to perform their job-related duties;

f) The identification and evaluation of alternative reasonable accommodation(s); and

g) The identification and evaluation of the extent to which the individual's impairment poses a direct threat, if any, to the safety of themselves or others.

Please forward all assessments, records & information to:

Chief Human Resources Officer
Yeshiva University,
2495 Amsterdam Avenue, BH 204
New York, NY 10033

THIS FORM SHOULD BE ACCOMPANIED BY A SIGNED COPY OF YESHIVA UNIVERSITY'S DISABILITY ACCOMMODATIONS HEALTH CARE PROVIDER RELEASE FORM.