Brookhaven National Laboratory	**MEDICAL CERTIFICATION,** **REQUEST FOR REASONABLE ACCOMMODATION(S) FORM**

PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS FORM:

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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

NOTE TO EMPLOYEES/PROVIDERS: The Health Care Provider completing this form may not disclose the underlying diagnosis without the Employee/Patient's consent.

To be completed by **EMPLOYEE**			
	Employee Name:		
	Job Title:	**Department:**	
	Employee Signature:		**Date:**

To be completed by **HEALTH CARE PROVIDER**			
	INSTRUCTIONS: Your patient has requested a reasonable accommodation in order to perform his/her job with Brookhaven Science Associates (BSA). BSA requires medical certification of the nature and extent of the patient's impairments or limitations resulting from his/her medical condition in order to determine if and how BSA can accommodate those impairment(s)/limitation(s). □ Attached is a copy employee's job assessment form which identifies the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. □ Please be sure to discuss with the patient the job duties, responsibilities and functions of the patient's job and the physical/mental demands and environmental conditions of the job. **Please complete and sign this form and return it to the patient to provide it to BSA, or you may return it directly to BSA via Confidential Fax No. 631-344-7366. If you have any questions, or require any assistance or information, please contact BSA's Occupational Medicine Clinic at Telephone No: 631-344-3666.**		
	Health Care Provider Name (Please Print):	**Specialization/Type of Practice:**	
	Address:		**Phone #:**

I. THE PATIENT'S IMPAIRMENT/CONDITION - The information sought in this Section I pertains only to the impairment(s)/condition(s) for which the patient is requesting a reasonable accommodation from the Company.

To be completed by **HEALTH CARE PROVIDER**

1. Does the patient have one or more physical or mental impairment(s)/condition(s)? Yes ☐ No ☐

2. Is the impairment(s)/condition(s) permanent? Yes ☐ No ☐

3. Is the impairment(s)/condition(s) long-term? Yes ☐ No ☐

4. If long-term, how long will the impairment/condition likely last?

_____

5. Because of the impairment/condition, is the patient substantially limited in one or more major life activities? Yes ☐ No ☐

6. If yes, what major life activity(s) is/are limited:

☐ caring for self	☐ walking	☐ hearing	☐ lifting
☐ interacting with others	☐ standing	☐ seeing	☐ sleeping
☐ performing manual tasks	☐ reaching	☐ speaking	☐ concentrating
☐ breathing	☐ thinking	☐ learning	☐ working
☐ toileting	☐ sitting	☐ reproduction	

☐ operation of a major bodily function: _____

☐ other: _____

II. POSSIBLE REASONABLE ACCOMMODATION(S)

To be completed by **HEALTH CARE PROVIDER**

7. How does the patient's limitation(s) in major life activities interfere with his/her ability to perform specific job duties or functions of his/her position with BSA?

_____

_____

_____

_____

_____

II. POSSIBLE REASONABLE ACCOMMODATION(S) – Cont'd

To be completed by the **HEALTH CARE PROVIDER**

8. Please describe possible accommodations that you believe would enable the patient to overcome the limitations resulting from his/her impairment(s)/condition(s), and why you believe these accommodations would be effective.

If you believe that leave would be an effective accommodation, please provide the duration of recommended leave.

To be completed by the **HEALTH CARE PROVIDER**

9. Please provide any other information you believe is relevant and may be helpful:

SIGNATURE OF HEALTHCARE PROVIDER:	**Date:**

*** ALL INFORMATION PROVIDED ON THIS FORM WILL BE MAINTAINED AS CONFIDENTIAL AND IN A FILE SEPARATE FROM THE PATIENT'S PERSONNEL FILE ***