New York City Transit/MTABC/SIRTOA

Reasonable Accommodation(s) for Disability or Pregnancy-Related Condition Employee/Applicant Medical Certification Form

To be completed by the EMPLOYEE/APPLICANT	
Name:	
BSC ID Number:	**Badge/Pass Number:**
Job Title:	**Department:**
Telephone Number(s):	
E-mail Address:	
Manager:	

ALL REQUESTS: Please identify the accommodation(s) you are requesting and the reasons for your request below:

CURRENT MTA EMPLOYEES: What aspects of your job will this accommodation assist you with? Which job duties specifically do you require an accommodation to reasonably perform?

Employee's Signature:	Date:

Please complete and sign the attached release of health information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

When the form is complete, please email the form to: reasonableaccommodations@nyct.com

If you have questions, please contact:

Designee of Reasonable Accommodations (DRA) Ronald Liburd 347-643-8154

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To be completed by the HEALTHCARE PROVIDER	
Instructions to the Physician: Your patient, the employee/applicant listed above, has requested a reasonable accommodation for a disability or pregnancy-related condition. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a physical or mental impairment, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine eligibility for a reasonable accommodation.	
Provider Name (please print):	
License Number:	**State:**
Type of Practice/ Medical Specialty:	
Business Address:	
Phone Number:	**Fax Number:**

1. **Based on your conversation with the patient, please list your understanding of the essential functions of the patient's job.**

2. **Does the patient have a physical or mental impairment? Yes ______ No ______**

3. **Please describe the patient's physical or mental impairment, not just the diagnosis.**

4. **When did the physical or mental impairment begin?**

5. **How long is the physical or mental impairment expected to last?**

To be completed by the HEALTHCARE PROVIDER (Continued)

6. **Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the patient's physical or mental impairment or accompanying treatment.**

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7. **What limitations caused by the physical or mental impairment affect the patient's ability to reasonably perform the essential functions of their job?**

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8. **What adjustments to the work environment, work schedule or job responsibilities would enable the patient to reasonably perform the essential functions of their job?**

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9. **How long will the patient need the reasonable accommodation? If unable to provide date, when will they be medically reevaluated?**

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10. **Additional Comments or Suggestions:**

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I do hereby certify that to the best of my knowledge the above information is true and correct.

Healthcare Provider Signature: _______________ **Date:** _______________