University Health Services

Occupational Health Services
McCosh Health Center
Princeton University
Washington Road
Princeton, NJ 08544

609.258.5035 (phone)
609.258.0976 (fax)

Request for Medical Information from Healthcare Provider

Date: _____ PUID#: _____

Employee's Name: _____ DOB: _____

Dear Healthcare Provider,

Your patient is employed at Princeton University. Occupational Health Services in partnership with Human Resources works to ensure employees remain engaged in the workforce and are able to safely perform their jobs. We require additional and specific medical information to determine if this employee is able to perform the essential functions of the job with or without accommodations. Please provide complete, specific and legible answers to the questions below. Thank you for assisting your patient and Princeton University Occupational Health Services' clinical staff.

I authorize my treating provider to release the requested information to Princeton University Occupational Health Services' clinical staff and the Human Resources ADA Accommodations Manager.

Employee's signature: _____Date: _____

1. Patient's diagnoses and onset of diagnoses. If applicable include current or ICD-10 or DSM-V diagnosis:

_____

_____

2. How long have you been treating your patient?

_____

3. Please list all scheduled testing and treatment plans associated with this condition.

_____

_____

_____

4. Include a list of all medications prescribed by you and all the patient's providers.

_____ _____

_____ _____

_____ _____

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5. Please describe the condition's current functional impact, including severity, frequency and pervasiveness and the ways in which the condition may affect the individual's functioning in their current job/role:

_____

_____

6. Please describe the expected progression or stability of the condition including information about expected changes in the functional impact of the disability over time and/or the cyclical or episodic nature of the condition.

_____

_____

7. If your patient is on leave, please provide the estimated time frame for return to work with or without accommodations. _____

8. If your patient will require job accommodations, **please review job description** provided by Princeton University and/or the employee. After review and consideration of the essential functions of the job, does their condition allow work with or without accommodations? Yes◉ No○

a. If your patient requires job restrictions or accommodations in order to perform the essential functions of their job, please outline these requirements below.

_____

_____

b. Include the duration of restrictions or accommodations needed to permit the patient to perform the essential functions of their job.

_____

I hereby acknowledge and verify by my signature that the information provided is accurate, complete, and current.

Healthcare Provider's Signature _____ **Date** _____

Print Healthcare Provider's Name _____

State/License # _____

Address _____

Phone _____ **Fax** _____