912 Norwich New London Turnpike,
Unit #5, Uncasville, CT 06382.
p-(860)848-0514, f-(860)-848-0523
www.Creativepotentialllc.com

Verification of Physical or Mental Impairment

The **Creative Potential employee** named below is requesting an accommodation due to a stated physical or mental impairment. When an impairment and/or need for accommodation are not obvious or already known, **Creative Potential requires** an employee's attending healthcare provider to verify the nature and extent of the stated impairment. The information provided on this *Verification of Physical or Mental Impairment Form* must be based on current clinical and diagnostic data.

Patient/Employee Name: ______________________ Telephone Number: ______________

Address: ____

____

PLEASE NOTE:

The Genetic Information Nondisclosure 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.

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To Be Completed by Healthcare Provider:
(If necessary, please attach additional pages)

1. Have you diagnosed the patient with a:
Mental or psychological disorder ___ Yes ___ No
Physical impairment? ___ Yes ___ No

If you answered "No" to both of these questions, it is not necessary to proceed further. Please sign where indicated below and return this form to the address shown.

If you answered "Yes" to either question, please specify the nature of each disorder and the date of initial diagnosis: *(If there is more than one diagnosis, please label them Condition #1, Condition #2, etc.)*

____
____
____

2. Does the diagnosed condition(s) in your response to Question 1 have a limiting effect on the patient's ability to perform certain major life activities, such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, or working?

___ Yes ___ No

3. Does the diagnosed condition(s) in your response to Question 1 have a limiting effect on the patient's operation of major bodily functions, including the operation of an individual organ within a body system (e.g., the operation of the kidney, liver, or pancreas) or functions of the immune system, special sense organs and skin, normal cell growth, digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, or reproductive functions?

___ Yes ___ No

If you answered "No" to both Questions 2 and Question 3 it is not necessary to proceed further. Please sign where indicated below and return this form to the address shown.

If you answered "Yes" to either Question 2 or Question 3, please specify each limiting effect for each diagnosed condition:

____
____
____
____

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4. For each limiting effect dealing with a major life activity listed above in your response to Question 2 and/or Question 3:

a.) Is the patient unable to perform the activity to the same extent that the average person in the general population can perform the activity?

Condition #1 ______________________ ___ Yes ___ No
Condition #2 ______________________ ___ Yes ___ No
Condition #3 ______________________ ___ Yes ___ No

b.) Is the patient *substantially limited** as to the condition, manner, or duration under which he or she can perform that major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform that same major life activity?

Condition #1 ______________________ ___ Yes ___ No
Explanation ____

Condition #2 ______________________ ___ Yes ___ No
Explanation ____

Condition #3 ______________________ ___ Yes ___ No
Explanation ____

**The following factors should be considered in determining whether an individual is "substantially limited":*

The term "substantially limits" should be construed broadly in favor of expansive coverage, to the maximum extent permitted by the terms of the ADA.

1. An impairment is a disability if it substantially limits the ability of an individual to perform a major life activity as compared to most people in the general population.

2. An impairment need not prevent, or significantly restrict, the individual from performing a major life activity in order to be considered substantially limiting.

3. The determination of disability should not require extensive analysis.

4. The determination of whether an impairment substantially limits a major life activity requires an individualized assessment.

5. Although determination of whether an impairment substantially limits a major life activity as compared to most people will not usually require scientific, medical, or statistical evidence, the use of such evidence is not prohibited if appropriate.

6. With the exception of ordinary eyeglasses or contact lenses, the determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative (beneficial) effects of mitigating measures.

7. An impairment that substantially limits one major life activity need not substantially limit other major life activities in order to be considered a substantially limiting impairment.

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8. An impairment that is episodic (such as epilepsy) or in remission (such as cancer) meets the definition of disability if it would substantially limit a major life activity when active.

9. An impairment does not have to last for more than six months in order to be considered substantially limiting under the first or the second prong of the definition of disability.

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ATTESTATION BY HEALTHCARE PROVIDER:

By signing where indicated below I acknowledge that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief; that it constitutes my best professional judgment and opinion; and that the patient did not prepare or draft a response for my signature.

Physician Signature: ___________________________________ Date: ___________________

Printed Name: ____ Professional Status: ________

Address: _____________________________________ Phone: ___________________________

____ E-mail: ___________________________

Please return this information marked “Confidential” to:

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