

**Attending Medical Professional Statement   
for Medical Accommodation**

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| Name of employee: | Date Symptoms Appeared: | |
| Position & Responsibilities at Acadia: | | |
| Is the employee experiencing a chronic or recurring medical issue? | | |
| Have you determined that there is an objective medical diagnosis? | | |
| Based on the objective medical and work requirements, does the employee have a medical condition that requires accommodation to enable the employee to carry out their job duties? | | Yes  No |
| Please provide the general nature of those conditions, including any restrictions or limitations on work duties. Please ensure the information clearly states how the patient’s medical condition affects their ability to do their job: | | |
| Please indicate what accommodations would be required in the workplace that would allow the patient to carry out their job duties: | | |
| Please indicate the duration of the medical accommodation: | | |
| Please indicate the next appointment/assessment date: | | |
| Is there any further information we should consider in support of the request for medical accommodation? | | |
| Attending medical professional: | Date: | |
| Contact Numbers: | | |
| Email: | | |

**TO BE COMPLETED BY EMPLOYEE:** I authorize my Treatment Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to fully complete this report and release to Acadia University, HR Dept. I understand that my personal medical information will be kept confidential, with only functional abilities and limitations information provided to my manager.

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| --- | --- |
| Employee Signature: | Date: |

**Forward this form to the Human Resources Department via:   
Email:** [**kerry.deveau@acadiau.ca**](mailto:kerry.deveau@acadiau.ca) **or Fax: 902-585-1075**

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| **Completed by Human Resources Department** | | | |
| Approved for Medical Accommodation:  Yes  No | Effect Start Date: | | End Date: |
| Comments: | | | |
| Authorized Signature: | | Date: | |