REASONABLE ACCOMMODATION
HEALTH CARE PROVIDER RELEASE FORM

(THIS FORM TO BE COMPLETED BY THE EMPLOYEE/APPLICANT)

Complete this form to authorize your Health Care Provider to disclose information related to your request. Submit this completed form to your certified Health Care Provider, along with copies of the Reasonable Accommodation Request Form and the Health Care Provider Statement Form.

SECTION 1- APPLICANT/EMPLOYEE INFORMATION	
Name:	DOB:
Address:	Phone #:
	Email:

SECTION 2- HEALTH CARE PROVIDER INFORMATION

Name: _ _____

Practice/Specialty: _____

Address: _____ Phone #: _____

Please forward completed forms directly to:
Yeshiva University, University Benefits
2495 Amsterdam Avenue, BH 824, New York, NY 10033 or via fax 212 -960-0034