

**Reasonable Accommodations for Employees and Job Applicants with Disabilities and Employees
Who Are Pregnant or Have Pregnancy Related Conditions**

In accordance with the Americans with Disabilities Act and Massachusetts law, the College of the Holy Cross provides reasonable accommodations to enable qualified individuals with disabilities and employees who are pregnant or have pregnancy related conditions to perform the essential functions of their jobs, gain access to the workplace and enjoy equal benefits and privileges of employment. The College also provides reasonable accommodations to qualified individuals with disabilities during the hiring process in compliance with law.

While each situation is different and require a case-by-case approach, these procedures describe how the College will typically process requests for reasonable accommodations for employees and applicants.

Definitions

For the purposes of these procedures, applicable federal and state anti-discrimination law definitions of disability,¹ mental impairment, physical impairment, major life activities, substantially limits, undue hardship, qualified individual, and essential functions apply. See **APPENDIX D: DEFINITIONS OF DISABILITY**.

In addition, the following terms have the following meanings:

Pregnancy or Pregnancy Related Condition. Pregnancy or any condition related to an employee's pregnancy including, but not limited to, lactation or the need to express breast milk for a nursing child if the employee requests such an accommodation.

Accommodation Related to Pregnancy or Pregnancy Related Condition. Accommodations Related to Pregnancy or Pregnancy Related Condition include, but are not limited to: (i) more frequent or longer paid or unpaid breaks; (ii) time off to attend to a pregnancy complication or recover from childbirth with or without pay; (iii) acquisition or modification of equipment or seating; (iv) temporary transfer to a less strenuous or hazardous position; (v) job restructuring; (vi) light duty; (vii) private non-bathroom space for expressing breast milk; (viii) assistance with manual labor; or (ix) a modified work schedule; provided, however, that an employer shall not be required to discharge or transfer an employee with more seniority or promote an employee who is not able to perform the essential functions of the job with or without a reasonable accommodation.

Procedures for Employees and Job Applicants

1. Accommodation Request Procedure for Applicants. Applicants for employment in non-faculty positions should contact the Associate Human Resources Director for Employee Relations in Human Resources to request an accommodation for the application process. Applicants for employment in faculty positions should contact the Dean for Diversity, Equity and Inclusion/Chief Diversity Officer, in the Office of the Provost and Dean of the College.²

¹ Massachusetts law (M.G.L. c. 151B) uses the term "handicap" which for the purpose of these procedures is included by reference in the definition of "disability."

² Employers are prohibited from asking disability-related questions before making an offer of employment. An exception, however, is if an applicant asks for reasonable accommodation for the hiring process in which case applicants may be asked to describe the accommodation(s) they are seeking to enable them to participate in the application process. However, the forms in Appendix A should not be used in connection with this inquiry. If the need for this accommodation is not obvious, the College

2. Accommodation Procedure for Employees.

- a. Requesting Accommodations. Generally, employees must let the College know that they need an accommodation because of a disability or an accommodation related to pregnancy or pregnancy related condition.

Employees should contact the Associate Human Resources Director for Employee Relations or notify their supervisor of the need for an accommodation orally or in writing. Whenever employee makes a request for an accommodation³ to a supervisor, the supervisor should promptly refer the request to Human Resources. In situations where it is impossible or impractical for the employee to make this request, the College will also accept a request from a legally authorized family member, health care provider, or other representative who is legally authorized to make such requests on behalf of an individual with a disability.

- b. Interactive Process.

- i. The College will engage in an interactive process and dialogue with the employee to determine whether the individual has a disability, the need for the accommodation, the impact of the mental impairment or physical impairment or condition on the employee's ability to perform the essential functions of the position, and what accommodation is appropriate, and for what duration; provided, however, that the dialogue may not be necessary in situations in which the existence of the disability and the need for the accommodation is obvious, the College and the individual agree on the most effective reasonable accommodation, and the accommodation does not impose an undue hardship on the College.
- ii. The College seeks to put in place accommodations to address the particular needs of the individual with the disability taking into consideration the job's essential functions. *When the need for the accommodation is obvious, the College will move directly to the accommodation process* (otherwise, see subsection (iii), below). The College and the individual will engage in the interactive process to discuss requested accommodation(s) and alternatives to arrive at a reasonable accommodation that is appropriate in the particular circumstances. The College is not required to provide the exact accommodation requested, and no specific form of accommodation is guaranteed (except with respect to accommodations related to pregnancy or pregnancy related condition as set forth in subsection (iv) below). Accommodations that create an undue hardship on the College, compromise the health and safety of members of the College community, or fundamentally alter the nature of the College's employment or academic mission on the College are not required.

may ask an applicant for reasonable documentation about his/her/their disability, including documentation from an appropriate professional concerning his/her/their disability and functional limitations. The College should make clear to the applicant why it is requesting such information, i.e., to verify the existence of a disability and the need for an accommodation.

³ Supervisors should inform Human Resources when employees request adjustments or changes at work for a reason related to a medical or mental health-related condition, and not just when employees use the term "accommodation."

- iii. Employee Disability Accommodation Request Form (APPENDIX A). When the need for the accommodation is not obvious,⁴ the College may ask the employee for reasonable documentation about the disability, functional limitations and need for accommodation. In such cases, the employee should complete the Disability Accommodation Request Form and submit it to Human Resources. If the accommodation request concerns an Assistance Animal in College Housing, the employee should complete the form **EMPLOYEE DISABILITY ACCOMMODATION(S) REQUEST FORM– ASSISTANCE ANIMAL IN COLLEGE HOUSING (APPENDIX E)**.
- iv. It is the responsibility of the individual requesting the accommodation to provide sufficient information, upon request, to support the need for the requested accommodation. In some cases, this might include medical documentation as described in subsection (vi) below. However, , medical documentation is not required in connection with a request for the following accommodations related to pregnancy related condition: (A) more frequent restroom, food or water breaks; (B) seating; (C) limits on lifting more than 20 pounds (unless that is an essential function of the position); and (D) private non-bathroom space for expressing breast milk.
- v. As part of the interactive process, Human Resources may contact the appropriate supervisor or departmental official(s) for the purposes of discussing possible accommodations, including consideration of a number of relevant factors, including, but not limited to:
- The nature and duration of the requested accommodation;
 - The impact of the requested accommodation on the performance of the essential functions of the employee’s position;
 - The impact of the requested accommodation on other employees, students, or College operations and academic mission;
 - Alternative possible accommodations;
 - The financial impact of the requested accommodation.
- vi. Additional Medical Documentation.
- (1) When the disability and/or need for accommodation is not obvious, and/or the information provided by the employee in the Employee Disability Accommodation Request Form is insufficient to substantiate that the employee has a disability and/or the nature of the reasonable accommodation, the College may determine medical documentation must be obtained from the employee’s treating health care provider. Generally, it is the employee’s responsibility to obtain the additional requested medical documentation from the health care provider. See form below, **APPENDIX B: “Request for Medical Information for Disability Accommodation(s)”**, which includes an “Authorization for Disclosure of Protected Health Information” that a health care provider may require, followed by a questionnaire for the health care provider to complete. Medical documentation is not required in connection with a request for the following accommodations for pregnancy or a pregnancy related condition: (i) more frequent restroom, food or water breaks; (ii) seating;

⁴ For example, when a disability is not clearly visible.

(iii) limits on lifting more than 20 pounds (unless that is an essential function of the position); and (iv) private non-bathroom space for expressing breast milk.

- (2) Medical documentation of a disability and the need for accommodation should be recent and sufficient to substantiate that the employee has a disability, the functional limitations due to the disability and a description of the accommodation requested.
The “Request for Medical Information for Disability Accommodation” form may be used by employees to request medical information from the medical.

If the employee provides insufficient documentation in response to the College’s initial request, Human Resources will explain why the documentation is insufficient and allow the employee an opportunity to provide the missing information in a timely manner.

- (3) The College may request the employee’s written consent (as required by the Health Insurance Portability and Accountability Act of 1996, or HIPAA) to consult with or request supplemental medical information from the employee’s health care provider(s) directly in connection with a request for reasonable accommodation when the employee provides insufficient information to substantiate that he/she/they have a disability and need for a reasonable accommodation.
- (4) In addition, if the employee provides insufficient documentation from his/her/their health care provider to substantiate the disability and need for a reasonable accommodation,⁵ or if the College needs additional information in order to make an appropriate decision regarding a proposed accommodation, the College may request that the employee undergo an independent medical evaluation⁶ at the College’s expense. The independent medical exam will be limited to determining the existence of a disability and/or the functional limitations that require a reasonable accommodation.
- (5) Failure to timely provide sufficient documentation or to cooperate with the College’s efforts to obtain such documentation may result in a denial of an accommodation request.

- vii. The ultimate determination for providing reasonable accommodations rests with Human Resources, after consultation with supervisory staff in appropriate circumstances. If no reasonable accommodation will be made, then Human

⁵ Insufficient documentation may also include, but are not limited to, where the health care professional does not have expertise to give an opinion about the particular condition and limitations, the information does not specify the functional limitations due to the disability or factors indicate the information is not timely or credible.

⁶ In certain other circumstances, a medical evaluation that is job-related and consistent with business necessity may be required, including if the College reasonably believes that an employee's ability to perform the essential functions of his/her/their job will be impaired by a medical condition or that s/he/they will pose a direct threat to the health or safety of the employee or others due to a medical condition.

Resources will notify the employee in writing including the rationale for that decision.

- viii. Accommodation Plan. Once an accommodation has been deemed appropriate and reasonable, both the employee and the departmental supervisor are notified by Human Resources and an accommodation plan is implemented for the duration specified. The accommodation plan is monitored by Human Resources and reviewed on occasion to ensure the accommodation enables the employee to complete the necessary work tasks and to ensure effectiveness. Modifications to the accommodation plan can be made if the conditions change and/or the nature of the work performance/duties changes. Human Resources must be contacted to re-engage the interactive process.
3. Confidentiality. Information provided through the accommodation process will be kept confidential and securely by Human Resources in accordance with applicable law. Any written information regarding an employee's disability, accommodation request and medical condition must be kept separate from the employee's regular personnel file. Disclosure to the College personnel (e.g., employee's supervisor(s) or department chair being told about necessary accommodations) may be permitted if such individual needs to be informed in order to assess requests for, implement, or monitor accommodations but the information to be shared will be limited to that necessary to determine whether an accommodation would be reasonable and to implement the accommodation. The Office of Disability Services and/or Facilities may be consulted for technical assistance regarding what accommodations are appropriate and available. The Office of the General Counsel may also provide guidance, particularly if it appears that a requested accommodation imposes an undue hardship or that the employee cannot perform the job effectively or safely even with accommodation. Information may also be provided to personnel called on to provide emergency medical treatment or government officials investigating compliance with disability laws or regulations. Personnel who participated in the evaluation or implementation of an accommodation request must not share information about an employee's medical condition or disability with other employees, or inform other employees that an accommodation is being provided because of an employee's medical condition or disability, unless the employee reporting the medical condition or disability has consented to the disclosure or otherwise in accordance with applicable law or business necessity.⁷
4. Grievance Procedure. If an individual feels that he/she/they have been unfairly denied a reasonable accommodation, or has a concern about perceived discrimination or discriminatory harassment based on disability, the complaint should be directed to the Director of Human Resources pursuant to the procedures set forth in the Discriminatory Harassment Policy.
5. Financial Responsibility for Accommodations. Individual departments are responsible for the costs of equipment and expenses normally related to its employees, including expenses of reasonable accommodations made related to individuals with disabilities. If an accommodation is deemed appropriate and reasonable for an employee or applicant, then the department bears the responsibility for funding the accommodation, where required by law. In the interactive accommodation process, if the department feels that the accommodation would be an undue hardship, the department must work with Human Resources to provide a suggestion for an alternative accommodation or make a formal written request for additional funding to the Associate

⁷ In response to co-worker questions, supervisors may indicate that the College is acting for legitimate business reasons or in compliance with federal and state law (rather than disclosing the existence of a reasonable accommodation).

Director for Budgets in the Finance Office or the Director of Finance, outlining the accommodation requested, the cost, and any other relevant information.

6. No Retaliation. It is a violation of College policy to retaliate against an individual for requesting or receiving an accommodation for a disability in good faith.

APPENDIX A: EMPLOYEE DISABILITY ACCOMMODATION(S) REQUEST FORM

**COLLEGE OF THE HOLY CROSS
Employee Disability Accommodation(s) Request Form**

The purpose of this form is to assist the College to determine eligibility and the need for reasonable accommodations.

Please submit this form with sufficient medical documentation as described in Reasonable Accommodations for Employees and Job Applicants with Disabilities.

Your request for an accommodation, and any information submitted in support of or related to the request, will be kept confidential in accordance with applicable law and as described in the College’s procedures entitled “Reasonable Accommodations for Employees and Applicants with Disabilities.”

Any questions regarding the reasonable accommodation process should be directed to Human Resources.

TO BE COMPLETED BY THE EMPLOYEE:

1. Employee, Department and Supervisor Information

Name: _____

Position: _____ Department: _____

Email: _____ Phone: _____

Supervisor’s Name and Title: _____

2. Please identify and describe the physical, mental or cognitive condition⁸ for which you are requesting an accommodation:

3. Please describe any limitations resulting from your condition that interfere with your ability to perform the essential functions of your position, and the expected duration of each such limitation:

4. Please describe the accommodation(s) you are seeking to enable you to perform the essential functions of your position safely and effectively, and the expected duration of each such accommodation:

By signing below, I acknowledge and agree that I am responsible for providing sufficient medical documentation from my health care provider(s) to substantiate my disability and need for reasonable

⁸ Please do not provide any genetic information on this form or if you are asked to provide medical information to support your request for accommodation. Federal law prohibits employers from requesting genetic information of an employee or an employee’s family member unless an exception applies. “Genetic information” includes your family medical history, the results of your or your family member’s genetic tests, the fact that you or your family member sought or received genetic services, and genetic information of a fetus or embryo.

accommodation as described in College's procedures entitled "Reasonable Accommodations for Employees and Applicants with Disabilities."

Printed Name

Signature

Date: _____

BELOW TO BE COMPLETED BY HUMAN RESOURCES:

Date request received by Human Resources:

Decision and Accommodation(s) Granted, if any:

Date employee informed of decision and accommodation(s) granted, if any:

**APPENDIX B: REQUEST FOR MEDICAL INFORMATION FOR DISABILITY
ACCOMODATION(S)**

COLLEGE OF THE HOLY CROSS
Request for Medical Information for Disability Accommodation(s)

Dear Health Care Provider,

Your patient is employed at the College of the Holy Cross, and has requested accommodation(s) in the workplace. We require additional specific medical information to be able to review this request. Please provide complete, specific and legible answers to the questions below. Your patient has indicated consent to your providing this information (see below). Thank you for assisting your patient and the College of the Holy Cross.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize my treating health care provider:

_____, to disclose to, and discuss with, the College of Holy Cross, the requested protected health care information, records, and any opinions concerning my physical or mental impairment and ability to perform essential job-related functions to determine appropriate accommodations. I understand that my protected health information may include information related to my psychiatric health, drug/alcohol abuse, communicable diseases, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date signed.

I understand that I may revoke this consent at any time, except to the extent that action has already taken place in reliance upon it. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. I understand that I may inspect or copy the information to be disclosed in accordance with applicable law. I release the source of this information from any and all liability resulting from its release. I understand that this authorization is valid only for a period of one year from the date below.

Patient Signature: _____ Date: _____
Print Name: _____ DOB: _____
Witness Name: _____ Witness Signature: _____

Please complete the information below and submit this and any additional clinical information requested to:

Department of Human Resources
Attn: Associate Human Resources Director for Employee Relations

Preferred method of delivery:

via fax: 508-793-3575

Alternative method of delivery, via mail or hand deliver to:
O’Kane Hall, 072

College of the Holy Cross
One College Street
Worcester, MA 01610

1. Please describe the patient's mental or physical impairment(s) for which accommodations are needed, including diagnosis, severity, prognosis, and expected duration. If the employee is currently unable to work and requires a medical leave, please state the expected duration of this leave:⁹

2. Does the physical and/or mental impairment(s) substantially limit the patient's ability to perform a major life activity¹⁰ when compared to the average person in the general population? Please identify the activity.

3. What essential function(s) of the patient's job (if attached, please refer to description of the employee's job function(s)) are impacted by the mental or physical impairment(s)?

4. Please suggest work place modifications, auxiliary aids or services that are necessary to enable your patient safely and effectively to perform the essential functions of the job, together with an explanation of each recommended accommodation and its relevance to the impairment.

⁹ Please do not provide any genetic information. Federal law prohibits employers from requesting genetic information of an employee or an employee's family member unless an exception applies. "Genetic information" includes family medical history, the results of patient's or patient's family member's genetic tests, the fact that patient or patient's family member sought or received genetic services, and genetic information of a fetus or embryo.

¹⁰ Major life activities include both activities and major bodily functions. Activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, walking, speaking, breathing, learning, working, sleeping, eating, standing, lifting, bending, reading, concentrating, thinking, and communicating. Major bodily function include, but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

5. Please provide the dates of the initial meeting and most recent meeting between you and the employee:

6. What is the expected duration of the impairment(s) and/or functional limitation(s)?

7. [IF ADDITIONAL INFORMATION IS REQUIRED, DESCRIBE HERE. INFORMATION REQUESTED MUST BE JOB-RELATED AND CONSISTENT WITH BUSINESS NECESSITY]

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

Print Name of Health Care Provider: _____

Signature of Health Care Provider: _____ Date: _____

State license number: _____

APPENDIX C: HELPFUL RESOURCES

Campus Accessibility Map - <https://www.holycross.edu/health-wellness-and-access/office-disability-services/handicap-parking-map>

Service Animal and Assistance Animal

Policy https://www.holycross.edu/sites/default/files/files/policyprocedure/studentaffairs/20171012_service_and_assistance_policy_to_post.pdf

Discriminatory Harassment Policy

<http://college.holycross.edu/policiesforms/administration/HarassmentPolicywithNoticeFINAL.pdf>

For information regarding medical leaves, faculty should contact the appropriate Dean of Faculty and other employees should contact the Associate Director of Human Resources for Employee Relations. College ADA/504 Coordinator: David Achenbach, Department of Human Resources, College of the Holy Cross, One College Street, Worcester, MA 01610, dachenba@holycross.edu.

Reporting Access Issues:

- Issues concerning access to buildings and grounds, including but not limited to access issues involving snow removal, curb cuts and non-operable automatic door openers: The Director of Facilities Operations in Facilities.
- Issues regarding accessibility of electronic resources: The ITS Help Desk or the Chief Information Officer.

APPENDIX D: DEFINITIONS OF DISABILITY

FEDERAL

“For the purposes of federal disability nondiscrimination laws (such as the Americans with Disabilities Act (ADA), Section 503 of the Rehabilitation Act of 1973 and Section 188 of the Workforce Innovation and Opportunity Act), the definition of a person with a disability is typically defined as someone who (1) has a physical or mental impairment that substantially limits one or more "major life activities," (2) has a record of such an impairment, or (3) is regarded as having such an impairment.”

<https://www.dol.gov/odep/faqs/general.htm>; see also 42 U.S.C. 126 Sec. 12102

MASSACHUSETTS

“An individual with disability is someone:

- 1) with a mental or physical impairment that limits one or more major life activities; or
- 2) who has a history of such an impairment; or
- 3) who is perceived (even if erroneously) as having such an impairment.”

<http://www.mass.gov/ago/consumer-resources/your-rights/civil-rights/disability-rights/employment-rights.html>; see also M.G.L. c. 151B, Sec 1.

**APPENDIX E: EMPLOYEE DISABILITY ACCOMMODATION(S) REQUEST FORM–
ASSISTANCE ANIMAL IN COLLEGE HOUSING**

COLLEGE OF THE HOLY CROSS

Employee Disability Accommodation(s) Request Form

The purpose of this form is to assist the College to determine eligibility and the need for reasonable accommodations in connection with a request for an Assistance Animal in College housing¹¹.

Please submit this form with sufficient medical documentation as described in Reasonable Accommodations for Employees and Job Applicants with Disabilities.

Your request for an accommodation, and any information submitted in support of or related to the request, will be kept confidential in accordance with applicable law and as described in the College’s procedures entitled “Reasonable Accommodations for Employees and Applicants with Disabilities.”

Any questions regarding the reasonable accommodation process should be directed to Human Resources.

TO BE COMPLETED BY THE EMPLOYEE:

5. Employee, Department and Supervisor Information

Name: _____

Position: _____ Department: _____

Email: _____ Phone: _____

Supervisor’s Name and Title: _____

6. Please identify and describe the physical, mental or cognitive condition¹² for which you are requesting an accommodation:

7. Please describe any limitations resulting from your condition that interfere with your ability to enjoy the equal benefits and privileges of housing, and the expected duration of each such limitation:

8. Please describe the accommodation(s) you are seeking to enable you to enjoy the equal benefits and privileges of housing, and the expected duration of each such accommodation:

¹¹ A request for a *Service Animal* should be submitted on the form in Appendix A. The definitions of *Service Animal* and *Assistance Animal* are in the Service Animal and Assistance Animal Policy at https://www.holycross.edu/sites/default/files/files/policyprocedure/studentaffairs/20171012_service_and_assistance_policy_to_post.pdf.

¹² Please do not provide any genetic information on this form or if you are asked to provide medical information to support your request for accommodation. Federal law prohibits employers from requesting genetic information of an employee or an employee’s family member unless an exception applies. “Genetic information” includes your family medical history, the results of your or your family member’s genetic tests, the fact that you or your family member sought or received genetic services, and genetic information of a fetus or embryo.

By signing below, I acknowledge and agree that I am responsible for providing sufficient medical documentation from my health care provider(s) to substantiate my disability and need for reasonable accommodation as described in College's procedures entitled "Reasonable Accommodations for Employees and Applicants with Disabilities."

Printed Name

Signature

Date: _____

BELOW TO BE COMPLETED BY HUMAN RESOURCES:

Date request received by Human Resources:

Decision and Accommodation(s) Granted, if any:

Date employee informed of decision and accommodation(s) granted, if any:

APPENDIX F: REQUEST FOR MEDICAL INFORMATION FOR DISABILITY ACCOMODATION(S) – ASSISTANCE ANIMAL IN COLLEGE HOUSING

COLLEGE OF THE HOLY CROSS
Request for Medical Information for Disability Accommodation(s)

Dear Health Care Provider,

Your patient is employed at the College of the Holy Cross, and has requested accommodation(s) in College provided housing. We require additional specific medical information to be able to review this request. Please provide complete, specific and legible answers to the questions below. Your patient has indicated consent to your providing this information (see below). Thank you for assisting your patient and the College of the Holy Cross.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize my treating health care provider:

_____, to disclose to, and discuss with, the College of Holy Cross, the requested protected health care information, records, and any opinions concerning my physical or mental impairment and ability to enjoy the equal benefits and privileges of housing to determine appropriate accommodations. I understand that my protected health information may include information related to my psychiatric health, drug/alcohol abuse, communicable diseases, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date signed.

I understand that I may revoke this consent at any time, except to the extent that action has already taken place in reliance upon it. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. I understand that I may inspect or copy the information to be disclosed in accordance with applicable law. I release the source of this information from any and all liability resulting from its release. I understand that this authorization is valid only for a period of one year from the date below.

Patient Signature: _____ Date: _____
Print Name: _____ DOB: _____
Witness Name: _____ Witness Signature: _____

Please complete the information below and submit this and any additional clinical information requested to:

Department of Human Resources
Attn: Associate Human Resources Director for Employee Relations

Preferred method of delivery:

via fax: 508-793-3575

Alternative method of delivery, via mail or hand deliver to:
O’Kane Hall, 072

6. What is the expected duration of the impairment(s) and/or functional limitation(s)?

7. [IF ADDITIONAL INFORMATION IS REQUIRED, DESCRIBE HERE. INFORMATION REQUESTED MUST BE RELATED TO THE ENJOYMENT OF THE EQUAL BENEFITS AND PRIVILEGES OF HOURING AND CONSISTENT WITH BUSINESS NECESSITY]

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

Print Name of Health Care Provider: _____

Signature of Health Care Provider: _____ Date: _____

State license number: _____