MEDICAL INFORMATION TO SUPPORT A REASONABLE ACCOMMODATION REQUEST TO BE COMPLETED BY A MEDICAL PROVIDER

All sections must be filled out thoroughly and be legible.

The purpose of this document is to request information regarding your medical condition(s). This information is needed to determine whether, under applicable laws, you have a disability that requires a reasonable accommodation and, if so, what accommodations would enable you to perform the essential functions of your position and/or enjoy the benefits and privileges of your employment. This request is part of the interactive process mandated by the Equal Employment Opportunity Commission. To consider your request for a reasonable accommodation, an assessment of your condition is required by a licensed medical provider. An acceptable diagnosis of your condition must include the information stated below.

Please give a copy of this document along with a copy of your position description, work schedule (days in office) and DPMAP to your medical provider, so they are aware of your current position, work schedule, and essential functions.

Applicant/Employee Name:_____

Job Title: _____

Date: _____

1. Does this applicant/employee currently have a physical or mental impairment?
   - ☐ No
   - ☐ Yes

2. Describe each impairment(s) in detail, including diagnosis?

3. For each impairment listed above, does this impairment substantially limit a major life activity?
   - ☐ No
   - ☐ Yes. Describe below in detail each limitation and the impact on daily activity; to include, severity, and extent/duration of the impairment. For example, functional limitations, symptoms, side effects of treatments. If the impairment is episodic in nature, describe how often the applicant/employee is impaired and to what extent the applicant/employee is impaired during episodes.

4. What major life activity is substantially limited by the above impairment?

☐ Caring for Self	☐ Performing manual tasks	☐ Walking
☐ Seeing	☐ Hearing	☐ Speaking
☐ Breathing	☐ Learning	☐ Lifting
☐ Working	☐ Sitting	☐ Standing
☐ Reaching	☐ Bending	☐ Interacting with other people
☐ Communicating	☐ Concentrating	☐ Eating
☐ Sleeping	☐ Major bodily functions	☐ Reading
☐ Immune	☐ Normal Cell Growth	☐ Digestive
☐ Bowel	☐ Bladder	☐ Genitourinary
☐ Hemic	☐ Special Sense Organs and Skin	☐ Lymphatic
☐ Neurological	☐ Brain	☐ Respiratory
☐ Circulatory	☐ Endocrine	☐ Reproductive
☐ Musculoskeletal	☐ Cardiovascular	

☐ Other:_____

5. Describe to what extent the applicant/employee is limited in each major life activity identified above. Please be as specific as possible about the restriction (s) (for example, cannot walk more than 10 feet, cannot stand for more than 20 minutes, cannot concentrate for more than 1 hour at a time, etc.).

6. If temporary, state how long the impairment is expected to last.

7. How does the applicant's/employee's impairment affect their ability to perform the essential functions of their job? (Provide your medical provider a copy of your position description/DPMAP or list of essential functions and work schedule) to assist him/her in answering this question.) Describe any limitations in detail.

8. An applicant/employee must be able to complete the essential functions of the job with or without a reasonable accommodation. If the applicant/employee is not able to perform the essential functions of the position, please provide your suggested-specific accommodation(s) that you believe would enable the applicant/employee to perform the essential functions of the position and how/why the accommodation(s) will assist the applicant/employee in performing their essential functions.

9. If an accommodation is not granted, is there potential for injury to the applicant/employee or to others while performing the essential functions of the position?

☐ No

☐ Yes. Describe in detail the nature and likelihood of injury.

10. If telework is requested and/or recommended as an accommodation, please identify how often the applicant/employee will need to telework due to their impairment (s) and why?

11. If full-time telework is requested and/or recommended as an accommodation, is the applicant/employee able to commute to the office when mission requires for mandatory meetings, trainings, and events? If no, why not?

12. Is the applicant/employee able to travel to and from work or for work requirements? If not, why and please specify the travel restrictions. If, yes how often and are there any limitations while traveling?

13. Are there any other accommodations the employer should consider to address the employee's impairment(s)?

14. Please provide any additional information you believe would be necessary or helpful in determining the applicant/employee's need for accommodation.

_____	_____	_____
Medical Provider's Printed Name/Title	Provider's Stamp	Medical Provider's Signature

Date: _____

Medical Provider's Address: _____

Medical Provider's City/State/Zip code: _____

Medical Provider's Phone number: _____

Medical Provider's Fax number: _____

Privacy Act Statement: The Rehabilitation Act of 1973, 29 U.S.C. section 791, and Executive Order 13164 authorize collection of this information. The primary use of this information is to consider, decide and implement requests for reasonable accommodation. Additional disclosures may be: To medical personnel to meet a bona fide medical emergency, to another Federal Agency, a court, or a party in litigation before a court or in an administrative proceeding being conducted by a Federal agency when the Government is a party to the judicial or administrative proceeding's; to a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of the individual; and to an authorized appeal grievance examiner, formal complaints examiner, administrative judge, equal employment opportunity investigator, arbitrator or other duty authorized official engaged in investigation or settlement of a grievance, complaint or appeal filed by an applicant/employee.

Optional Medical Information Release Authorization:

I,_____hereby authorize_____ __ _____(State Medical Providers Name) to release and send to the DLA Equal Employment Opportunity Office, Disability Program Coordinator (DPC) I am working with, the following information:

_____

I understand that the purpose of this information is to help determine the extent of my disability, its effect on work activities, and any need for reasonable accommodation to enable me to perform my job. I understand that the DLA Equal Employment Opportunity Office may have to share the provided information with those who have a need-to-know. I understand that I can revoke this authorization any time by providing written revocation to the DPC I am working with to process my RA request.

Employees Name (Print)_____

Employee's Signature_____ Date_____