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 welcome condition is required by a licensed medical physician. 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 to your medical provider, so they are aware of your current position.

Employee Name: _____

Job Title: _____

Date: _____

1. Does this employee currently have a physical impairment?

   ___No

   ___Yes

   Does this employee currently have a mental impairment?

   ___No

   ___Yes

   Describe the impairment(s) in detail, including diagnosis:

2. Does this impairment substantially limit a major life function?

___No

___Yes. Describe below in detail the limitation and impact on daily activity; to include past, present, and future nature, severity, and duration of the impairment. For example, functional limitations, symptoms, side effects of treatments;

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

___Caring for one's 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

___Other:

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4. The duration of the impairment is:

   ___Temporary

   ___Permanent

   ___Provide in detail how long the RA is needed:

5. Can the impairment be controlled or mitigated by medication or other medical intervention?

   ___No

   ___Yes. Describe any limitations in detail:

6. Employee should provide you a copy of their position description or a list of their essential functions. Is the employee able to perform the full duties/essential functions of the position?

   ___Yes

   ___No. Describe any limitations in detail:

7. An employee must be able to complete the essential functions of the job with or without a reasonable accommodation. If the employee is not able to perform the full duties of the position, please note any specific accommodation(s) that you believe would enable the employee to perform the full duties of the position and how the accommodation will assist the employee in performing the duties:

8. If an accommodation is granted, is there potential for injury to the employee or to others while performing the essential functions of the position?

___No

___Yes. Describe in detail the nature and likelihood of injury:

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9. Please state how the functional limitations affect the ability to perform the essential functions of the job and how the reasonable accommodation requested will enable the employee to perform those functions.

10. List any additional information you believe would be necessary or helpful in determining the employee's need for accommodation.

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

Date: _____

Address: _____

City/State/Zip code: _____

Phone number: _____