Medical Documentation Request and Release Form

Section A – To Be Completed by the Employee

Requestor Name **RAR Case Number**

I am requesting a reasonable accommodation for a medical condition that may qualify as a disability. To support this request, I authorize my health care provider to release the medical information requested in Section B of this form to the Disability Program Manager (DPM) and other designated agency officials involved in processing my request. This information will be used solely to evaluate and respond to my reasonable accommodation request.

Employee Signature **Date**

Note: This information will be maintained in a confidential file separate from official personnel records, in compliance with the Privacy Act and EEOC regulations.

Instructions for Health Care Provider

Pursuant to the EEOCs Enforcement Guidance on Reasonable Accommodation and Undue Hardship under the Americans with Disabilities Act, sufficient medical documentation must include the following information: a description of the diagnosed medical condition (if the employee consents to disclosure); the nature, severity, and anticipated duration of the condition; a statement describing how the condition limits the employees ability to perform specific job functions or major life activities; any recommended accommodations or restrictions to support the employee in the workplace.

The employee listed above has requested reasonable accommodation. Please answer the following questions as thoroughly as possible. Attach additional pages if needed.

Note: The employer is entitled only to documentation necessary to establish that a disability exists and that it necessitates reasonable accommodation. Do not include extraneous medical information.

Section B – To Be Completed by the Health Care Provider

Provider Name
Specialty
Phone **Fax/Email**
Address

1. Diagnosis (if employee has consented to disclosure):

2. Is this a physical or mental impairment that substantially limits one or more major life activities?

☐ No ☐ Yes

If yes, please describe the nature and extent of the limitations, including major life activities affected (e.g., walking, standing, seeing, concentrating):

3. Expected duration of the condition or limitations:

☐ Permanent ☐ Temporary – Expected to last until: _____

4. Functional limitations in the work environment (be specific):

Explain how the condition impacts the employee's ability to perform essential job functions.

5. Recommended accommodation:

List any accommodations you believe would assist the employee in performing job functions or reducing barriers in the work environment.

Note: You are not required to identify specific accommodation but may do so if you are aware of potential options.

Provider Certification

I certify that the above information is accurate based on my professional knowledge and treatment of the patient.

Provider Signature **Date**