

Date: ____

REASONABLE ACCOMMODATION HEALTH CARE PROVIDER STATEMENT FORM

(THIS FORM TO BE COMPLETED BY THE HEALTH CARE PROVIDER)

App	olicant/Employee Name:	DOB:
proc	above noted individual has requested a reasonable accommodation cess, perform the essential functions of a job, or to participate in other information requested on this form will assist in making a determination	terms, conditions and privileges of employment.
add	RUCTIONS : The following form must be completed in detail and sign itional pages or records as needed. Do not provide information unrelation submitted will be kept confidential to the extent permitted by the confidential to the confidential to the extent permitted by the confidential to the confidential	ated to the reasonable accommodation request.
SECTION 1- HEALTH CARE PROVIDER INFORMATION		
Name:		DOB:
Practice/Specialty:		Phone #:
Address:		Email:
Health Care Provider: List information pertaining to your applicable degrees, area(s) of specialization, board certifications, and/or licenses:		
SECTION 2 – VERIFICATION:		
Verification by a Health Care Provider must meet the following criteria:		
a)	Documentation must provide a confirmation of disability, or other medical-related need for accommodation, and include a medical recommendation for a specific reasonable accommodation. <u>Note</u> : Documentation need not include details of a medical diagnosis	
b)	The documentation must be written on the official letterhead or other organizational form of the health care provider.	
c)	The health care provider's credentials must be identified.	
d)	The documentation must be dated and signed by the health care provider.	
e)	Describe the limitations in detail as they currently exist and only in relationship to the job process, and state whether the disability, or other medical-related need for accommodation, is ongoing or temporary. If temporary, specify the date the disability, or other medical-related need for accommodation, is expected to no longer require an accommodation.	
f)	Indicate the extent to which the accommodation will permit the individual to participate in the job application process, perform the essential functions of the job, or to participate in other terms, conditions and privileges of employment.	
g)	g) If equipment purchase is recommended, please be specific. If work modification, restructuring or sharing of specific duties is recommended, describe the recommended action and be specific.	

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. For more information about the GINA Act, please visit http://www.eeoc.gov/laws/types/genetic.cfm

The identification and evaluation of the extent to which the individual's impairment poses a direct threat, if

any, to the safety of themselves or others.