REQUEST FOR REASONABLE ACCOMMODATION FOR A DISABILITY

Part 1: To be completed by Employee or Applicant

1. Name: _____
2. Date: _____
3. Telephone Number: _____
4. Work Location (Court and jurisdiction): _____
5. Name of Requester (if other than the Employee or Applicant): _____

6. I hereby authorize and request _____, health care provider, to provide any information regarding my medical condition as it relates to the performance of the essential functions of my job. I understand that this information will be used solely for the purpose of evaluating my request for reasonable accommodation and the information will remain strictly confidential. Disclosure will be made to those individuals necessary to aid in determining and implementing reasonable accommodations.

_____

Employee's or Applicant's signature Date

Part 2: To be completed by licensed medical provider

1. Does the Employee or Applicant above have a physical or mental impairment? ☐ **Yes** ☐ **No**
   If *yes*, please describe the impairment:
   _____
   _____
   _____

2. What is the disability, condition, or functional limitation for which an accommodation is requested?
   _____
   _____
   _____

3. Please specify what workplace accommodation is needed for each disability, condition or functional limitation: _____
   _____
   _____

4. Please describe how the request relates to the employee's job or workplace. *For example*: "Patient is having trouble getting to work at scheduled starting time because of medical treatments." – or – "Patient needs six weeks off to get treatment for a back problem.": _____
   _____
   _____
   _____

5. How long will the accommodation be needed? _____
   _____
   _____
   _____

6. Is the accommodation request time sensitive? If yes, please explain. _____
   _____
   _____

7. Has the Employee or Applicant had any accommodation(s) in the past for the same limitation? If yes, what were they and how did the accommodation(s) help them perform their job? _____
   _____
   _____

Medical Professional's Printed Name: _____

Medical Professional's Signature: _____ Date: _____

Medical Providers - Please place a check mark next to your credentials below:

☐ M.D	☐ N.P.	☐ O.D.	☐ P.A.	☐ Psy.D.
☐ D.M. D	☐ PT, DPT	☐ CRNP	☐ Other_____	

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. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.