



NOTE: THIS IS A DRAFT SAMPLE POLICY FOR A HANDBOOK TO BE TAILORED TO A COMPANY'S PARTICULAR PRACTICE AND UPDATED PER CURRENT FEDERAL, STATE, AND LOCAL LAWS, AS WELL AS APPLICABLE CASE LAW FOR A GIVEN JURISDICTION (2-2012)

THIS POLICY DOES NOT CONSTITUTE LEGAL ADVICE. IT IS RECOMMENDED THAT USERS ASK THEIR LEGAL COUNSEL TO REVIEW THIS AND ANY OTHER POLICY BEFORE SHARING WITH EMPLOYEES

SAMPLE ADA ACCOMMODATION FORM - PHYSICIAN

CONFIDENTIAL

PLEASE RETURN TO [EMPLOYEE /PATIENT] OR [CONTACT PERSON AT COMPANY: NAME AND TITLE AND INCLUDE PHONE NUMBER] AT [COMPANY NAME AND ADDRESS] IN A CONFIDENTIAL MANNER

COMPANY NAME requests that the treating physician(s) of **EMPLOYEE NAME** ("Employee") provide information to enable **COMPANY** to assess whether there is a reasonable accommodation that **COMPANY** can provide to permit Employee to perform the essential functions of **his/her** position (**IDENTIFY JOB TITLE**).

A position description is enclosed. The information on the essential functions of the job is included in that position description. **Our employee has been advised that this form must be fully completed by you and returned no later than [DATE]. Failure to return the form by that day may jeopardize the Employee's continued employment.** Please consult this document in completing this form. If you have any questions, please contact _____ at _____.

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 employees or their family members. In order 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

Physician's Name _____

Telephone number: _____

Dates of Treatment: _____

Probable Duration of Condition: _____

Is Employee substantially limited in any major life activities as a result of his/her health condition? If so, please identify the major life activities.

Is Employee unable to perform any of the essential functions of his/her job as listed in the position description or limited in his/her ability to do so? If so, please identify each limitation or inability to perform and the expected duration.

Does the condition cause Employee any functional limitations (such as limitations in the ability to reach, stand, bend, grip, concentrate, speak, etc.)? If so, please describe the limitations and their expected duration.

Based upon your knowledge of Employee's condition, are there any accommodations that **COMPANY** can provide that you believe would permit Employee to perform the essential functions of his/her job?

Does Employee require leave from work or a reduced schedule as a result of his/her health condition? If so, please indicate what additional leave is required and/or what schedule of work Employee is able to adhere to and what you estimate to be the expected duration of this need.

Will the condition cause episodic flare ups periodically preventing Employee from performing his/her job functions and if so, please provide the anticipated frequency and duration of such flare ups as well as any accommodations that the employee will require as a result.

Please provide any additional information that you believe would assist **COMPANY** in determining, in consultation with Employee, whether an accommodation can be provided to permit him/her to perform his/her job at **COMPANY**. We stress that you should not provide information that would provide us with information that should not be disclosed under GINA (see introductory language in this form).

Dated: _____

Physician's Signature

Printed Name: _____

Type of Practice: _____

Business Name: _____

Phone Number: _____