Medical Request for ADA Accommodation

Employee's Name_____ Date_____

Healthcare Provider Contact Information

Treating Physician's Name_____

Name of Medical Practice_____

Mailing Address_____
Street Address

_____
City, State, Zip Code

Telephone Number_____

Fax Number_____

You have been identified as the above listed employee's primary healthcare provider in which to consult regarding a medical condition that may require an accommodation in the workplace. In order for the City of Statesboro to proceed, we require information about the employee's medical condition from a licensed healthcare provider. Enclosed is a copy of the Health Information Release Waiver Form submitted by the employee authorizing the Department of Human Resources to seek personal health information relating to any relevant medical condition(s).

The Americans with Disabilities Act (ADA) requires employers to provide reasonable accommodations to employees which have a medical condition that substantially limits a major life function. We are requesting that you complete the attached form to determine if the employee is covered under the ADA, and if so, the nature of the condition and which major life activities it substantially limits. In addition, please indicate what accommodations, if any, you believe the employee needs in order for him/her to perform the essential functions outlined in the enclosed job description. The employee has been asked to provide guidance as to what accommodations may be necessary.

After you have completed the medical documentation, please fax the documents to (912)489-6140 or email to tarrez.brown@statesboroga.gov.

If you have any questions, please contact Tarrez Brown at (912)212-2317.

For Internal Use Only:

Date Submitted to Physician's Office_____ Submitted By:_____

Submitted Via: _____Fax_____Email

Enclosed Documents:

- ❏ Waiver of Information Form
- ❏ Job Description

Medical Information Form for Health Practitioner

Employee's Name_____ **Date**_____

What is the nature of the illness/condition?_____

_____

_____

_____

_____

Check all major life functions that are limited as a result of illness/condition. Major life functions include but are not limited to the following:

❑ Caring for oneself	❑ Walking	❑ Seeing	❑ Hearing	❑ Speaking
❑ Performing manual tasks	❑ Breathing	❑ Learning	❑ Working	❑ Sitting
❑ Interacting with others	❑ Standing	❑ Lifting	❑ Thinking	❑ Concentrating

How does the illness/condition affect each major life function checked above? Provide an explanation for each major life function checked above. To what extent does the illness/condition limit the major life functions above? Please be specific._____

_____

_____

_____

_____

_____

H**ow long do you anticipate these accommodations to be required?**_____

_____

Practitioner's Signature_____ **Date**_____