Reasonable Accommodation Healthcare Provider Form

TO BE FILLED OUT BY EMPLOYEE:

Name:	Title:
Location:	Date of Accommodation Request:

TO BE FILLED OUT BY HEALTHCARE PROVIDER:

Date of Medical Exam:	

Does this employee have a physical or mental impairment?
☐ YES ☐ NO

Is this impairment:
☐ Permanent ☐ Temporary

If impairment is temporary, please indicate the duration of impairment:

If additional space is needed to answer the following questions, please continue on plain paper, note the question number, and attach to this form.

1. Please describe, in detail, the functional limitations of the employee:
____
____
____

2. Please review the attached job description and describe how and to what extent the employee's impairment affects his/her ability to perform the duties noted:
____
____
____

3. Please describe the reasonable accommodation that you believe would enable this employee to perform the essential duties of the position:
____
____
____

Please **STAMP** the following information:

Healthcare Provider Name:	Title:
Healthcare Provider's Address:	

____Date:_______________________
Healthcare Provider Signature