

Request for Information from Medical Provider

_____, who is an employee of _____ may have a disability covered under the Americans with Disabilities Act (ADA). We are seeking specific information as detailed below. Please provide the requested information only — please do not send copies of medical records.

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.

Note: The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities.

1. Does the employee have a physical or mental impairment? Yes No

2. What is the impairment? _____

3. What is the expected duration of the impairment?

Permanent

Temporary (please explain) _____

Chronic (please explain) _____

Episodic (please explain) _____

4. Does the impairment affect a major life activity? Yes No

(Examples of major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and the operation of a major bodily function such as the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive systems).

5. Does the impairment substantially limit one or more major life activity? Yes No

6. Does the employee have any functional limitations resulting from the impairment?

Please describe:

7. Please refer to the attached information regarding the employee's job that contains an explanation of the essential job functions. How does the functional limitation impact the employee's ability to perform the essential functions?

8. Do you have any suggestions for possible accommodations that will enable the employee to perform the essential functions? Please describe:

9. How would your suggested accommodation enable the employee to perform the essential functions?

10. Does the employee's condition, functional limitations or any identified accommodation create a risk to the safety of the employee, his/her coworkers, and/or the general public during the performance of the essential functions of the employee's position? Given the critical importance of this question, please explain your answer in detail below.

If additional space is needed to fully answer the above questions, please attach a supplement containing your complete responses.

Please return this form and any supplemental addendum to:

Contact: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Phone: _____ Fax _____

Completed by:

Signature of physician

(date)

Print name here