Department of Human Resources
Office of the ADA Coordinator

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Medical Information Request Form

(to be completed by healthcare practitioner)

Employee Name: ____ (please print)

1. Please describe the employee's medical condition ______________________________

   ____

   ____

2. When did the medical condition begin? ______________________________________

3. How long is the condition expected to last? ___________________________________

4. Please describe the seriousness of the condition (e.g., mild, moderate, severe): ______________

   ____

5. Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the medical condition or accompanying treatment**:**

   ____

   ____

   ____

   a. Please describe how these limitations impact the employee's ability to perform her/his job (please refer to employee's job description):

   ____

   ____

   ____

   What accommodation(s), if any, would you recommend for this employee? ______________

This document is confidential to the extent permitted by law

a. If the suggested accommodation is not permanent, what is the likely duration of the accommodation?

6. Is there other information we should be aware of when evaluating what accommodation is most appropriate?

Treating Healthcare Practitioner Signature	Treating Healthcare Practitioner Printed Name	Date