Interactive Process Request for Information from a Medical Provider

INSTRUCTIONS:

Your patient has requested accommodation in their employment with the District. In order to fully and fairly evaluate their request we need your assistance in documenting the nature and extent of any objective physical or mental limitations they currently experiencing, in relation to the essential functions of their job. Any information that you provide will be held in strict confidence and will be used solely for purposes of determining what reasonable accommodations, if any, might be appropriate.

EMPLOYEE INFO			
	NAME:	Other name(s) (if applicable):	EMPLOYEE NUMBER:
	ADDRESS:		WORK PHONE:
	CITY, STATE and ZIP:		HOME PHONE:

1. How long has the Employee been your patient?	2. Are you their regular medical provider?

3. Please describe all functional limitations that currently prevent the Employee from performing any of the duties listed on the attached job description. If no written job description has been provided, please base your discussion on your best understanding of the Employee's current job duties:

4. In your opinion, is the Employee able to perform their current job duties with or without accommodation?

5. During what time period have the functional limitations listed in your response to question number 3 existed for this Employee?

6. As best you can, please describe specifically how these functional limitations prevent the Employee from performing their duties:

7. In your opinion, what specific types of accommodation (if any) might help the Employee perform the duties which they are currently unable to perform?

8. Please describe specifically how the accommodations you recommended (if any) would permit the Employee to perform duties they are currently unable to perform?

9. Please describe any functional limitations preventing Employee from working either a full or reduced time schedule:

Additional comments:

MEDICAL FACILITY NAME (if applicable):	**LOCATION:**	**CONTACT PHONE:**
MEDICAL PROVIDER'S NAME (print):	**SIGNATURE:**	**DATE:**