



REQUEST FOR MEDICAL DOCUMENTATION

1. EMPLOYEE NAME

2. DATE (MM/DD/YYYY)

3. DUE TO RAC BY (MM/DD/YYYY)

4. Dear Health Care Provider:

I have requested an accommodation (*describe the requested accommodation here*)

To perform the essential functions of my position. Medical documentation is required to reflect my medical diagnosis, functional limitations caused by my diagnosis, and the parameters associated with my functional limitations. The information you provide in question 11 below will assist my agency with determining if I am an individual with a disability per the Rehabilitation Act and your recommended accommodations that may assist me with my known medical conditions/functional limitations.

5. THE FOLLOWING ARE THE KEY DUTIES I AM UNABLE TO PERFORM AND/OR THE BENEFITS/PRIVILEGES OF EMPLOYMENT I AM UNABLE TO ENJOY:

6. I HAVE BEEN GIVEN THE RESPONSIBILITY FOR DETERMINING IF YOUR PATIENT IS COVERED BY THE REHABILITATION ACT. I CANNOT PROCEED UNTIL I RECEIVE THE REQUESTED INFORMATION. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT ME AT THE TELEPHONE NUMBER BELOW.

7. RAC NAME

8. PHONE NUMBER

9. TITLE

10. PLEASE RETURN THIS FORM AND THE REQUESTED INFORMATION TO ME VIA ENCRYPTED EMAIL (*UTILIZING VA'S INTERNAL EMAIL SYSTEM*) OR BY MAIL AND/OR VIA FAX. (*ENTER COMPLETE E-MAIL ADDRESS, MAILING ADDRESS AND/OR FAX NUMBER.*)11. PLEASE **DO NOT** PROVIDE A COPY OF THE PATIENT'S COMPLETE MEDICAL HISTORY.

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.

The following medical information is requested:

(a) medical diagnosis to include nature, severity, and duration of the impairment;

(b) one or more of the activities the impairment limits (*walking, reaching, breathing, etc.*);(c) the extent or degree to which the impairment limits an activity (*i.e. walking no longer than 30 minutes, reaching above shoulder height, breathing in unfiltered air, must be within 10 feet of a restroom, etc.*);

PATIENT NAME: _____

(d) the reason the individual requires accommodation or the particular accommodation requested; and/or

(e) how the accommodation will assist the individual in applying for a job, performing the essential functions of the job, or enjoy the benefit of employment.

12. HEALTH CARE PROVIDER NAME

13. HEALTH CARE PROVIDER SIGNATURE

14. DATE OF SIGNATURE
(MM/DD/YYYY)

15. MEDICAL/PROFESSIONAL LICENSE CATEGORY (i.e., *Primary Care Provider*)

16. LICENSE NUMBER (Required) (i.e. *VA-1234567*)

17. EXPIRATION DATE (MM/DD/YYYY)

18. PHONE NUMBER

***** When sending this form via electronic means, please ensure the file is encrypted to protect the requester PII & PHI information.**

This form should be retained separately from the employee's Official Personnel Folder.