[Employer Letterhead]

 [Date]

[Health Care Provider Name & Address]

 Re: Health Care Provider Inquiry Form

Your patient, [Employee Name], is an employee of [Employer Name] and has requested an accommodation for his/her disability. To fulfill our responsibility under federal and California law, specific information is being requested at this time. An Employee Health Care Provider Release Authorization signed by the employee is attached. Please do not send copies of medical records or provide a medical diagnosis. Please read through the following questions and answer them to the best of your ability. Thank you in advance for your prompt reply. If you have any questions, please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

A job description which includes the essential functions is attached for the employee’s position. Our employee has been advised that this form must be completed by you and returned to no later than [Date]. Your information will be kept confidential. Employers must generally retain medical certifications and related documents separately from usual HR/personnel files.

Attached is a list of the essential functions for the above-named employee for his/her position.

Date accommodation to begin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date accommodation to end or is continuous until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Questions to help determine the employee’s specific impairments.**

In order to qualify for a reasonable accommodation under the ADA, an employee must have either a disability, which results in an impairment that limits one or more major life activities, or a record of such impairment. Your answers to the following questions may help determine whether the employee has such an impairment or record thereof. \*

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
2. Is the impairment long-term or permanent? ☐ Yes ☐ No

If not permanent, how long will the impairment likely last?

Please answer the following questions based on what limitation the employee has when his or her condition is in an active state.

1. Does the impairment limit a major life activity? ☐ Yes ☐ No

(Note: Does not need to significantly or severely restrict to meet this standard.)

1. Does the impairment limit the operation of a major bodily function? ☐ Yes ☐ No

(Note: Does not need to significantly or severely restrict to meet this standard.)

1. **Questions to help determine whether an accommodation is needed.**

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of a disability. Your answers to the following questions may help determine whether the requested accommodation is needed because of the disability.

* What limitation(s) is interfering with the employee’s job performance?
* What job function(s) is the employee having trouble performing because of the limitation(s)?
* How does the employee’s limitation(s) interfere with his or her ability to perform those job functions?
1. **Questions to help determine effective accommodation options.**

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship to the employer. Your answers to the following questions may help determine effective accommodations:

* Do you have any suggestions or recommendations regarding possible accommodations to allow the employee to perform the essential functions of the job? If so, what are your suggestions or recommendations?
* How would your suggestions aid the employee’s job performance?
* If no accommodation is necessary, please indicate.
1. **Other Comments:**
2. **Health Care Provider Information:**

Health Care Provider Name:

 (PLEASE PRINT)

Name of Health Care Practice:

Address:

City: State: ZIP:

Telephone:

Email:

Health Care Provider’s Signature:

Date:

Once completed, this form may be either returned to the employee, mailed to the address below, or email to the person below. The employee may choose either.

**\* 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.**