Request for Supplemental Medical Information

[Date]

[Employee's Personal Physician's Name]
[Address]
[City, State, Zip Code]

Re: Supplemental Medical Questionnaire Request

Dear [Doctor's Name]:

[Company Name] is requesting your assistance in obtaining the information needed to explore reasonable accommodations for your patient, [Employee Name], in compliance with the requirements of Title I of the Americans with Disabilities Act (ADA) and the Fair Employment and Housing Act (FEHA) and consistent with the organizational goals of [Company Name] to assist employees with reasonable accommodations.

[Company Name] is currently engaging with [Employee Name] to discuss all reasonable accommodation. As part of this process, we would appreciate your assistance to help us ensure that we have a full and correct understanding of any and all work restrictions/functional limitations that may be in need of accommodation to support [Employee Name].

[Company Name] is in receipt of your report dated [date] for [Employee Name] in which you provide the following: [summarize the report, return to work, restrictions and duration, etc.]

OR

[Company Name] has been informed by [Employee Name] that you are the treating physician and that you would be the correct person to provide the information needed in support of this process.

To this end, please assist with completing the attached Medical Questionnaire Form. **Please note that as part of this process, we are only seeking a listing of work restrictions/functional limitations and their duration, if any. Please do not provide any information pertaining to medical condition, diagnosis, or treatment.**

Thank you for your assistance in this matter. As further decisions regarding accommodation are pending your reply, I look forward to your response as soon as possible and **not later than [date].**

Sincerely,

[Name]
[Title]

cc: Employee
Employee's Reasonable Accommodation/Medical File

Enc.: Essential Functions Job Analysis/Job Description
Medical Questionnaire

MEDICAL QUESTIONNAIRE

Date of Examination:

I have reviewed the job description/job analysis for [Employee Name]'s position of [position title] and can provide the following clarification *(check boxes and insert text as appropriate)*:

1. **Does [Employee Name] have a physical or mental impairment that limits his/her ability to engage in a major life activity such as the ability to work; care for his/herself; perform manual tasks; walk, see, hear, eat, sleep; or engage in social activities?**

   ☐ NO, [Employee Name] does not have a physical or mental impairment that limits his/her ability to engage in a major life activity.

   ☐ YES, [Employee Name] has a ☐ Physical and/or ☐ Mental impairment that limits his/her ability to engage in a major life activity.

2. **If the answer to question 1 is yes, does the impairment currently affect [Employee Name]'s ability to perform the essential functions of a [position title] *(see attached job description)*?**

   ☐ NO, [Employee Name's] impairment does not limit his/her ability to perform all of the essential functions of his/her position.

   ☐ YES, [Employee Name's] impairment does affect his/her ability to perform the essential functions of his/her position.

3. **If the answer to question 2 is yes, what work restrictions or functional limitations does his/her disability produce that are in need of accommodation? Please be as specific as possible *(e.g., if providing a restriction to standing, how many minutes can the subject stand before he/she would need to sit for X minutes)*. List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them.**

   ☐ Restrictions are **temporary through [date]** ☐ Restrictions are **permanent**

   List all physical activity restrictions.

   ☐ NO repetitive lifting/carrying of _____lbs. or more
   ☐ NO lifting/carrying of _____lbs. or more
   ☐ NO repetitive pushing/pulling of _____lbs. or more
   ☐ NO pushing/pulling of _____ lbs. or more
   ☐ NO at (or above) shoulder level reaching > _____ sec./min.
   ☐ NO repetitive keyboarding in excess of _____min. per hour
   ☐ NO prolonged walking in excess of _____min.
   ☐ Other *(please be specific)*

   ☐ NO repetitive bending/stooping > _____ times/row
   ☐ NO repetitive squatting/kneeling > _____ times/row
   ☐ NO prolonged standing in excess of _____ min.
   ☐ NO prolonged sitting in excess of _____ min.
   ☐ Must alternate sitting/standing every _____ min.
   ☐ NO running/jumping/climbing *(circle your answer)*

   Additional Clarification/Restrictions

   _____

   _____

   _____

4. **Does [Employee Name]'s continued assignment to the job of [position title] pose a significant risk of substantial harm to the health and safety of the employee or others?**
   ☐ NO
   ☐ YES, complete questions 5 and 6 below.

5. **If the answer to question 4 is yes, identify the duration, nature, severity, likelihood, and imminence of each specific risk.**

   _____

   _____

   _____

6. **If the answer to question 4 is yes, identify any specific work restrictions(s) that, if accommodated, would reduce or eliminate the risk(s) described in question 5.**

   _____

   _____

   _____

7. **Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee.**

   _____

   _____

   _____

_____ _____

[Doctor's Name] Original Signature **Date**

_____ _____

Print Name **Physician License Number**

PLEASE RETURN A COPY OF THIS FORM VIA FAX TO:

Disclaimer: Sample document only. Participants are encouraged to contact their legal counsel prior to relying on any sample documents or forms.
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