Employee Disability Accommodation
Healthcare Provider Information Form

This form is to be used by employees requesting reasonable accommodation and their healthcare provider(s) to verify that a functional limitation due to a disability exists, describe how the disability limits the employee's functioning and explain how those limitations affect the employee's ability to perform specific job functions. Information related to a request for accommodation is held in a confidential file separate from employee personnel records.

Date:_____

Employee Name:_____

Employee's work unit:_____

To be completed by the Healthcare Provider:

The above named individual has a functional limitation due to a disability, defined as "a substantial limitation of one or more major life activities":

☐ Yes ☐ No

Please describe how the limitation(s) impact the individual's functioning:

Describe how the limitation affects the individual's ability to perform essential functions of their job:

Provider name:

License Number: State license is issued:

Preferred contact (phone # or email address):

Signature:_____