Agency Logo

Human Resources / Division / Unit

**Letter to Health Care Provider**

**DATE**

**Provider First Name Last Name, Title**

**Street Address**

**City, State, Zip**

**RE: Patient Name:**

**Dear \_\_\_\_\_ (Title):**

Dear Dr. **Last Name**:

We are working with one of your patients, **Employee Name**, who has informed us that they are having difficulties performing some or all of the essential functions of their job. We are seeking **limited** medical information in response to their request for an accommodation. The information you provide will help in identifying potential reasonable accommodations for this employee.

**Note to HR Staff: please delete this paragraph from the letter you send to the health care provider:** There are situations when the agency may **not** need to contact the health care provider. Include the paragraph below only if you plan to contact the health care provider AND the employee signed the release of information document.

**Employee name** has signed a Release of Information giving us their authorization to request this information from their health care provider. You can find their signed permission enclosed with this letter.

**Employee name**’s classification is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attached is a position description that identifies **Employee Name’s** essential job functions. Please advise us whether **Employee Name** can perform the essential job functions of the position, with or without accommodation. If an accommodation is necessary, please identify the accommodation(s) that would be effective to allow **Employee Name** to perform the essential functions of their jobs. If more than one accommodation would be effective, please identify the alternative accommodations. We encourage you to attach as much detailed information as you believe would be helpful for us in understanding **EMPLOYEE NAME’s** specific situation. We are not requesting medical records, information unrelated to the impairment which creates the need for accommodation, or any documentation which reveals genetic information.

Please help us to expedite this process by returning this questionnaire by **DATE**. You can give it to our employee for delivery. Thank you in advance for your cooperation and prompt response

Sincerely:

Name

Title / Human Resources

Agency

Attachments:

Authorization for Release of Information

Request For Accommodation

Health Care Provider Response Form

Position Description

**Caution:** *Per the Genetic Information Nondiscrimination Act of 2008 (GINA) our agency is not requesting or requiring genetic information of its employees or their family members. In order for us to comply with this law, we ask that you not provide any genetic information when responding to this request for medical information.*

*Furthermore, we are seeking information relevant to the medical condition noted by the employee on the Accommodation Request Form. We are reviewing to see if this individual has an ADA qualifying impairment. We are NOT requesting medical records unrelated to the impairment.*

Last revision: September of 2020