Department of Veterans Affairs

REQUEST FOR MEDICAL DOCUMENTATION

1. DATE

2. Dear Health Care Provider:

Your patient has requested an accommodation *(describe the requested accommodation here)*

because of functional limitations caused by his/her disability. Since the disability is not visible, and we do not have documentation on file, I would appreciate information that would allow me to determine whether this individual has a disability covered by the Rehabilitation Act of 1973. The information that you provide will also help me determine whether the requested accommodation will be effective in eliminating or minimizing the limitations caused by the disability.

3. The key duties that your patient has advised that he/she is unable to perform, or benefits and privileges of employment that he/she is unable to enjoy are:

4. 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.

5. MY NAME IS	6. MY PHONE NO. IS	7. MY TITLE IS

8. Please return this form and the requested information to me at:
(Enter complete mailing address and fax number.)

9. 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.
At present, we only need the following information:

(a) the 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;

(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 to enjoy a benefits of employment.

10. NAME OF HEALTH CARE PROVIDER	11. SIGNATURE OF HEALTH CARE PROVIDER	12. DATE OF SIGNATURE

13. MEDICAL/PROFESSIONAL LICENSE CATEGORY AND NUMBER

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