

# Reasonable Accommodation Request Form

Employee name: \_\_\_\_\_ Location/Dept.: \_\_\_\_\_

Job Title: \_\_\_\_\_ Employee ID Number: \_\_\_\_\_

**Please provide the following information in detail. Use additional pages as necessary:**

Identify your disability or physical or mental impairment(s) or health condition(s) related to your request. Please do not provide any information regarding health condition(s) that are unrelated to your request for accommodation.

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Explain how your health condition prevents you from completing your essential job functions in relation to your job description.

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What is the expected duration of your limitation(s):

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What specific accommodation or suggestion to accommodate are you requesting? If you are requesting a leave of absence, please indicate your estimated return-to-work date.

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Please provide any additional detail regarding your request.

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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

[COMPANY] Signature: \_\_\_\_\_ Date Received: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**  
**PURSUANT TO HIPAA, 45 CFR PARTS 160 AND 164**

I, [EMPLOYEE NAME], hereby authorize [MEDICAL PROVIDER NAME] to furnish my employer, [COMPANY NAME] ("Company"), and its representatives, information concerning my health and specifically provide information to the attached questions. I understand that this Authorization provides for the release of any present records and/or health information, including those concerning medications I have been prescribed and the diagnosis and treatment of mental or psychological health.

I provide this authorization related to any treatment from [DATE] to the present.

I understand that information used or disclosed pursuant to this Authorization may be re-disclosed by Company and/or its representatives and may no longer be protected by federal or state law. I understand that except to the extent that action has already been taken in reliance on this Authorization, I can revoke this Authorization at any time by submitting a notice in writing to Company, attention [COMPANY CONTACT NAME]. Unless revoked or otherwise specified, this Authorization will expire one (1) year from the date signed. I agree that a photocopy of this authorization will be valid as an original.

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, Company asks 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient or Representative

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

[COMPANY LETTERHEAD]

[DATE]

[MEDICAL PROVIDER NAME]

[ADDRESS]

RE: [EMPLOYEE NAME]

Date of Birth: [XX/XX/XX]

Dear Dr. [NAME]:

This letter seeks to obtain information regarding our employee, [EMPLOYEE NAME]. As you may be aware, [EMPLOYEE NAME] has stated that [S/HE] has experienced difficulty performing [HIS/HER] [JOB TITLE] job duties due to what [S/HE] has described as [DESCRIPTION OF MEDICAL ISSUE].

We value [EMPLOYEE NAME] as an employee and would like to work with [HIM/HER] to determine what, if anything, [COMPANY] can do to assist [HIM/HER] in performing [HIS/HER] job duties. Accordingly, we are requesting information regarding what, if any, accommodation(s) you recommend to enable [EMPLOYEE NAME] to continue working. For your convenience, we have attached a specific list of questions that [EMPLOYEE NAME] has authorized [COMPANY] to ask regarding [HIS/HER] condition(s), as well as [EMPLOYEE NAME]'s release authorizing you to provide the requested information to us. To further assist you, we have also enclosed a description of [EMPLOYEE NAME]'s job.

Kindly respond to the enclosed questions and, if appropriate, complete the enclosed certification form. Please forward the requested information to us by [DATE].

Thank you in advance for your cooperation, and please contact me if you have any questions.

Sincerely,

[NAME]

[JOB TITLE]

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**To Confirm Receipt, please complete the following:**

Health Care Provider's Printed Name:

Date:

Health Care Provider's Signature:

[INSERT  
JOB DESCRIPTION]

[COMPANY LETTERHEAD]

**QUESTIONS REGARDING [EMPLOYEE NAME]**

1. Please identify any impairment(s) and/or condition(s) you have diagnosed in [EMPLOYEE NAME] related to [HIS/HER] [CONDITION FOR WHICH EMPLOYEE IS REQUESTING ACCOMMODATION], including the nature, duration, and severity of such impairments.

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2. With regard to the impairment(s) and/or condition(s) identified in response to Question No. 1, please state whether, in your opinion, [EMPLOYEE NAME]'s impairment(s) and/or condition(s) limits [HIS/HER] ability to perform any of the essential functions of [HIS/HER] position.

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3. If you believe [EMPLOYEE NAME]'s impairment(s) and/or condition(s) limits [HIS/HER] ability to perform any of the essential functions of [HIS/HER] position, please identify the activities you believe are limited and describe the nature, duration, and severity of such limitation(s).

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4. In light of your responses to the questions above and the job description provided, in your opinion can [EMPLOYEE NAME] perform the essential functions of [HIS/HER] position?

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5. If you believe that [EMPLOYEE NAME] requires accommodation(s) to perform the essential functions of [HIS/HER] position, what accommodation(s) do you believe will assist [EMPLOYEE NAME]?

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6. If you believe a leave of absence will assist [EMPLOYEE NAME] in performing the essential functions of [HIS/HER] position, please indicate [EMPLOYEE NAME]'s estimated return-to-work date.

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**IF APPROPRIATE BASED ON YOUR RESPONSES AND EVALUATION, PLEASE  
COMPLETE THE FOLLOWING RETURN TO WORK CERTIFICATION.**

## **RETURN TO WORK MEDICAL CERTIFICATION**

### **PART 1: To Be Completed by Employee (please print)**

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First Name

Middle Initial

Last Name

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Employee's Position/Title

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Anticipated Return to Work Date

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Signature of Employee

Date

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### **PART 2: To Be Completed by Employee's Health Care Provider (please print)**

I certify that on \_\_\_\_\_ the named employee is able to resume performing the function(s) of [HIS/HER] position at [COMPANY] with or without reasonable accommodation. Necessary accommodation(s) is/are as follows:

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Signature of Health Care Provider

Date

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## Remote Work Policy

This policy addresses the Company's practices and expectations regarding remote work. Any questions about the policy should be directed to \_\_\_\_\_.

### Equipment

The Company will provide the appropriate equipment necessary for remote work. [The Company will determine, with information supplied by the employee and his or her supervisor, the equipment needs of each employee (including hardware, software, phone and other office equipment). The Human Resource and IT departments will serve as resources in making this determination.] [Employees should let their supervisor or a manager in Human Resources know if they need any particular supplies, equipment, or other resources to effectively perform their job duties that are not already provided.] The Company reserves the right to make determinations as to appropriate equipment, subject to change at any time.

The Company will also provide the employee with appropriate office supplies (pens, paper, etc.) as deemed necessary. **[If there is a process for ordering supplies through the Company, address that here.]**

Equipment supplied by the organization is to be used for business purposes only. Employees must sign an inventory of all company property received and agree to take appropriate action to protect the items from damage or theft. Upon termination of employment, all company property will be returned to the company, unless other arrangements have been made.

[Employees may supply their own equipment, if deemed appropriate by the Company. Equipment owned and supplied by the employee will be maintained by the employee. The Company accepts no responsibility for damage or repairs to employee-owned equipment.]

### Expenses

The Company will reimburse all necessary and reasonable business expenses that employees incur in connection with the performance of their job duties as required by law, including those expenses incurred as a result of working remotely. Pre-approval of certain business expenses may be required.

[The Company will pay employees a stipend of \$XX per month to cover anticipated necessary and reasonable business expenses they will incur as a result of working remotely (including but not limited to expenses for mobile or other devices, internet, and electricity). The \$XX monthly stipend will be considered taxable income and will be reported as such on wage statements and federal and state tax forms. If employees incur necessary and reasonable remote work business



expenses in excess of the \$XX stipend (net of taxes) in any given month, they may submit a request for reimbursement of them, along with documentation to substantiate the charges incurred.]

## **Security**

Consistent with the organization's expectations of information security, employees will be expected to ensure the protection of confidential or proprietary Company, client and/or patient information when working remotely. **[If the Company has a specific data security or privacy policy, it can be addresses or referenced here as applicable.]**

## **Work Schedules and Time Keeping**

Employees working remotely are expected to be available and accessible during their normal or scheduled working hours.

Employees who are not exempt from the overtime requirements of the Fair Labor Standards Act and/or state law are required to accurately record all hours worked using the Company's time-keeping system while working remotely.

Non-exempt employees are also expected to take meal and rest breaks pursuant to company policy while working remotely. The start and end time of meal breaks must be recorded using the Company's time-keeping system.

## **Safety**

Employees are expected to maintain their home workspace in a safe manner, free from safety hazards. [The Company will provide each employee with a safety checklist that must be completed at least twice per year. Injuries sustained by the employee in a home office location and in conjunction with his or her work duties are normally covered by the Company's workers' compensation policy.] Employees are responsible for notifying their supervisor and/or a manager in Human Resources of such injuries as soon as practicable.