Your Letterhead Heare

[Employee Name]

[Address]

[City, State, Zip Code]

Dear [Employee Name]:

This letter is a follow-up to our recent communications regarding your work status. [Company Name] is fully committed to complying with the Americans with Disabilities Act (ADA) and its recent amendments to ensure equal opportunity in all aspects of employment for qualified persons with disabilities. Our company also follows any state or local law that provides individuals with disabilities greater protection than the ADA.

To this end, we need to be clear about any reasonable accommodation requests you and/or your health care provider believe might be necessary to enable you to safely perform your essential job duties. Accordingly, please have your treating physician promptly complete the attached "Reasonable Accommodation Questionnaire".

Please return the completed questionnaire to me no later than [Date]. We will promptly follow-up with you as soon as we have received and reviewed the information from your health care provider.

Lastly, please also inform me of any reasonable accommodations you are personally requesting in addition to any that may be suggested by your health care provider. We would appreciate any such requests be made in writing and submitted to [Department/Supervisor] by [Date].

Sincerely,

[Signature]

[Printed Name]

[Date]

REASONABLE ACCOMMODATION QUESTIONNAIRE

Instructions: Please respond in writing to all questions in complete detail. Attach a separate sheet of paper as needed. Write legibly or type responses. Please provide [Employee Name] with your responses unless directed otherwise.

1. First, please read through all of the questions. Do you have enough information to provide meaningful responses? *Circle one:* Yes No

   If you answer "No," do not answer the remaining questions. Only sign and date this attachment below.

2. Next, please confirm that you have reviewed the job description for Employee's position, and discussed Employee's job duties with Employee, including Employee's usual work schedule. *Circle one:* Yes No

   If you answer "No," do not answer the remaining questions. Only sign and date this attachment below.

3. Next, please confirm that you have examined the Employee and are familiar with his or her relevant medical history. *Circle one:* Yes No

   If you answer "No," do not answer the remaining questions. Only sign and date this attachment below.

4. Does Employee have any medical impairment that would affect the Employee's ability to perform one or more job functions? *Circle one:* Yes No

   If you answer "No," do not answer the remaining questions. Only sign and date this attachment below.

5. Please explain the basis for your opinion. Discuss Employee's specific limitations, including how they affect the employee's job performance.

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6. What accommodations, if any, can be provided which would allow Employee to perform the job functions that you described as being limited above? Please explain the basis for your conclusions.

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7. Are you aware of any other information the Company should know to assess whether and to what extent Employee can work in Employee's current assignment? **DO NOT disclose any unrelated medical or personal information unless otherwise directed by Employee.**

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Doctor's Name (Printed) _____

Doctor's Signature _____ *Date* _____

***** Note: A medical doctor must sign this form. No substitute signatures are acceptable. *****