Request for Physician Certification of Accommodation Request

Dear Medical Professional:

An individual under your care has requested a reasonable accommodation from their employer. In order to assist with the process, we are requesting you to provide feedback to the following questions based on your medical expertise. Under the ADAAA, an employee has a disability if he/she has an impairment that "substantially limits" one or more major life activities. Additionally, the definition has been broadened to include someone with an impairment who is "regarded as" having a disability, provided that the impairment does not have an actual or expected duration less than or equal to 6 months.

When answering the questions below, please consider the above named individual when their condition is at its worst and without any accommodations in place.

Please return this form to the employee or directly to the Agency within 15 days of receipt.

PART I—REQUESTER'S CONTACT INFORMATION

Requester's Name:	Date of Accommodation Request:	Date of Medical Documentation Request:

PART II—DISABILITY INFORMATION

1. Given the ADAAA definition above, does the above named individual have a disability?

☐ Yes ☐ No

If yes, please provide detailed diagnosis/diagnoses (include ICD/DSM-V code):

2. What "major life activities" are impacted by this disability?

- ☐ Caring for oneself
- ☐ Seeing
- ☐ Eating
- ☐ Walking
- ☐ Lifting
- ☐ Breathing
- ☐ Reading
- ☐ Thinking
- ☐ Working
- ☐ Other _____
- ☐ Other _____
- ☐ Performing manual tasks
- ☐ Hearing
- ☐ Sleeping
- ☐ Standing
- ☐ Bending
- ☐ Learning
- ☐ Concentrating
- ☐ Communicating
- ☐ Operation of a major bodily function
- ☐ Other _____
- ☐ Other _____

3. What is the expected duration of the above impact to the employee's major life activities?

☐ Less than 6 months ☐ Greater than 6 months (but not permanent) ☐ Permanent

4. What specific work restrictions or accommodations, if any, do you recommend?

5. If you are recommending restrictions or accommodations, please provide the duration.

6. How will the above restrictions/accommodations enable the individual to perform the essential functions or enjoy employment benefits of their job?

7. Comments/additional considerations:

Health Care Provider's Address:	**Health Care Provider's Printed Name:**
	Health Care Provider's Signature:

PLEASE RETURN FORM TO:

DIA 7400 Pentagon
Attn: EO/Reasonable Accommodation
Washington, DC 20301

reasonableaccommodations@dodiis.mil
Phone: (202) 231-8178
Fax: (202) 231-6486

Authority: Federal Rehabilitation Act of 1973, as amended, Rehabilitation Act–29 CFR 1614.203, as amended, Americans with Disabilities Act, as amended, Executive Order 13164, "Establishing Procedures to Facilitate the Provision of Reasonable Accommodation," as amended.
Purpose: To evaluate information in response to a Reasonable Accommodation Request.
Routine Uses: Routine uses of the information are consistent with the Defense Reasonable Accommodations and Assistive Technology Records, System of Records Notice DoD 0007. Additional information is available at *https://www.federalregister.gov/documents/2021/07/22/2021-15601/privacy-act-of-1974-system-of-records*
Disclosure of Information: Providing this information is voluntary; however, failure to complete the form in its entirety could result in a denial or delay of the requested service.