Disability Rights WISCONSIN

Form: Request for Medical Information from Your Provider

This form shows what can be in medical documentation to support a reasonable accommodation request. It is not legal advice. For legal advice specific to your situation, please talk with an attorney.

About This Form

You may use this form to ask your provider for information to confirm or clarify your medical conditions. You can use this information to support your request for a reasonable accommodation or modification.

How to Use This Form

You can give this form to your provider or doctor to fill out. Once they have filled out the form, you can mail it, email it, or drop it off with your landlord, employer, or whoever you're asking for the accommodation, along with your reasonable accommodation or modification request. Keep a copy of the form and request for yourself. You can write down when you sent the request and when you are expecting a reply.

Request for Medical Information

(to be completed by clinician)

Your patient, _____ (DOB: _____),

is asking for their: ☐ housing provider ☐ employer ☐ other: _____

Name of housing provider, employer, or other entity:

_____,

to give a reasonable accommodation or modification for their disability to _____

_____

_____

Please give the following clinical information:

1. Does the patient have a physical or mental impairment that substantially limits one or more major life activities or major bodily functions?

   "Major life activities" include but aren't limited to: self care, manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, breathing, speaking, learning, reading, concentrating, thinking, communicating, or working.

   "Major life activity" also includes doing a "major bodily function," which may include but isn't limited to: immune system functions, normal cell growth, or digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, or reproductive functions.

   ☐ Yes ☐ No

   If no, stop here: your patient may not be eligible for reasonable accommodation or modification.

   If yes, which major life activities are substantially limited by the patient's impairments?

   _____

   _____

   _____

2. Does at least one of the major life activity limitations from Question 1 create a need for the accommodation or modification the patient is asking for?

Do you expect the accommodation or modification will help with the limitation or will the limitation be worse without the accommodation or modification?

☐ Yes ☐ No

If no, stop here: your patient may not be eligible for this reasonable accommodation or modification.

If yes, describe the connection between the limitation(s) from Question 1 and the requested accommodation or modification.

How will the accommodation or modification improve the limitation? Or how will the limitation be worse without the accommodation or modification? Try to describe the connection so someone unfamiliar with accommodations or modifications or the patient's condition can understand.

Name of clinician

Clinician's license type
(*LPC, LCSW, Psychologist, MD, etc.)*

Signature

Date