VA U.S. Department of Veterans Affairs

REQUEST FOR MEDICAL DOCUMENTATION

1. DATE	2. DUE TO RAC BY:

3. 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. 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.

4. 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:

5. 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.

6. RAC NAME	7. PHONE NO.	8. TITLE

9. Please return this form and the requested information to me via encrypted email (utilizing VA's internal email system) or by mail and/or via fax. *(Enter complete e-mail address, mailing address and/or fax number.)*

10. 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) medical diagnosis to include nature, severity, and duration of the impairment;

PATIENT NAME: _____

(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 *(i.e. walking no longer than 30 minutes, reaching above shoulder height, breathing in unfiltered air, must be within 10 feet of a restroom, etc.)*;

(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.

11. HEALTH CARE PROVIDER NAME	12. HEALTH CARE PROVIDER SIGNATURE	13. DATE OF SIGNATURE

14. MEDICAL/PROFESSIONAL LICENSE CATEGORY *(i.e., Primary Care Provider)*		
15. LICENSE NUMBER *(Required) (i.e. VA-1234567)*	16. EXPIRATION DATE	17. PHONE NUMBER

*** When sending this form via electronic means, please ensure the file is encrypted to protect the requestors PII &PHI information.

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