MEDICAL INFORMATION ATTACHMENT

TO BE FILLED OUT BY THE DOCTOR, HOSPITAL, OR OTHER HEALTH PROFESSIONAL

What is the nature of the disability and what are its functional limitations?

_____

_____

_____

_____

What are possible workplace accommodations that will enable the individual to perform essential duties in the attached position description or to enjoy the benefits and privileges of employment (Continue on separate sheet if necessary):

_____

_____

_____

_____

_____ _____

Signature of Health Professional **Date**