

**SAMPLE - Request for Medical Information**

Dear Dr. [name]:

[Employee name] a patient of yours, is employed as a [classification] with the [agency]. I received your [letter / statement] dated [date], wherein you indicated [insert relevant information]. Enclosed, please find a release signed by [employee name] which authorizes you to provide information regarding [his or her] current condition and any resultant limitations. I will use your information in evaluating [his or her] ability to perform the functions of [his or her] position and in determining whether accommodations in [his or her] work environment, schedule, or assignments are required and feasible.

Please provide your analysis of [employee's name] residual functional capacity and specifically comment on the following: **[Insert questions about employee's ability to perform the essential functions of his job. Using Maintenance Worker as the example, such activities could include, but would not be limited to: gross and fine finger motions required for minor repairs such as carpentry, painting, plumbing, electrical and masonry work; grip strength, lifting and carrying - how far - how often, weight limits; and any other applicable maintenance work - including work on any special events and seasonal functions that might impact his upper extremity function.]** I have enclosed a functional capacity assessment form and narrative which outlines the duties and responsibilities of [employee name]'s position. Please describe in detail any limitations or restrictions on [his or her] ability to perform the essential functions of [his or her] position and list any assistive devices, equipment, or any accommodation you believe would enable [employee name] to perform [his or her] duties and responsibilities.

To preserve confidentiality, please ensure that your response is sealed in the enclosed self-addressed, postage-paid envelope. If you have any questions or require additional information, please contact me at [telephone number].

Sincerely,

**[Authorized Signature]**

Enclosures **[enclose copy of release form signed by employee, narrative of job duties, functional capacity assessment form, and envelope.]**

c: [Employee's name]

**Authorization for Release of Information**

I, [employee name], hereby authorize [physician's name], to furnish written information to [employer name & title], my employer, regarding my residual functional capacity, any limitations or restrictions on

my ability to perform the functions of my position and any devices, equipment, or accommodations I require to enable me to perform these functions.

I understand that I may revoke this authorization at any time by sending a written statement to **[employer name and address]**. The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date on which this authorization is no longer in force. I understand that if I revoke this authorization, my employer may still use and disclose information for which an action has already been taken in reliance on this authorization.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***[The original form must be signed and retained by the employer with a photocopy forwarded to the physician.]***

*Revised 6/2013*