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MEDICAL INFORMATION SHEET

For use of this form, see Standard Operating Procedure (*SOP*) for Reasonable Accommodations for Individuals with Disabilities, Dated 16 May 2011; the proponent agency is CEEO.

PRIVACY ACT STATEMENT

The information you provide is covered by the Privacy Act of 1974, Title 5, U.S.C. 552a.

AUTHORITY: Collection of this information is authorized by Section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. 794.

PRINCIPAL PURPOSE: Used for processing requests for reasonable accommodation by Department of the Army civilian employees and applicants for employment.

ROUTINE USES: Information will be used for support documentation and for review by appropriate agency personnel for requests for reasonable accommodation as defined in the USACE Reasonable Accommodation Request SOP.

DISCLOSURE: Voluntary, however, failure to complete all appropriate portions of the form may lead to a delay in processing and / or denial of requests for reasonable accommodation on the basis of inadequate data.

TO BE COMPLETED BY HEALTHCARE PROVIDER.

1. EMPLOYEE'S NAME *(Last, First MI)*

2. PHYSICIAN'S NAME *(Last, First MI)*

3. OFFICE CONTACT TELEPHONE NUMBER

4. PHYSICIAN'S ADDRESS *(Street, City, State and Zip Code)*

5. DETAILED DIAGNOSIS OF REQUESTOR'S CURRENT MEDICAL CONDITION(*s*).

6. PROGNOSIS, INCLUDING PLANS FOR FUTURE TREATMENT AND AN ESTIMATED DATE FOR FULL OR PARTIAL RECOVERY.

7. WHETHER THE MEDICAL CONDITION(*s*) RESULTS IN ANY IMPAIRMENT.

8. THE NATURE, SEVERITY, AND DURATION OF THE IMPAIRMENT.

9. THE ACTIVITY OR ACTIVITIES THE IMPAIRMENT LIMITS.

10. THE EXTENT TO WHICH THE IMPAIRMENT LIMITS THE INDIVIDUAL'S ABILITY TO PERFORM / COMPLETE CERTAIN JOB FUNCTIONS REQUIRED IN INDIVIDUAL'S CURRENT POSITION *(analysis of position description required).*

11. WHY REQUESTOR REQUIRES REASONABLE ACCOMMODATION OR THE PARTICULAR REASONABLE ACCOMMODATION REQUESTED.

SIGNATURE CERTIFICATION

12a. PHYSICIAN'S NAME *(Last, First MI)*	b. DATE *(YYYYMMDD)*	c. PHYSICIAN'S SIGNATURE