State of Illinois
Department of Human Services

PHYSICIAN'S MEDICAL REVIEW

DHS is requesting disclosure of information that is necessary to assist in evaluating a reasonable accommodation request. Disclosure of this information is VOLUNTARY. All information will be kept confidential and used in compliance of applicable state and federal laws; and is regarded as protected Health Information subject to HIPPA Policy.

1) Employee/Applicant: ____________________ 2) Date of Birth: ____________

3) Home Address: ____________________ 4) Soc Sec No: ____________

5) Employed by: ____________________ 6) Address: ____________________

7) Employee/Applicant's Disability: ____________________

(includes a physical or mental impairment that substantially limits one more major life activities, which include such things caring for oneself, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, breathing, learning and working)

8) Major Life Limitation(s): ____________________

9) What are the specific essential job functions this person can't perform without a reasonable accommodation due to the disability?

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10) What type of reasonable accommodation do you suggest for the employee/applicant: ____________

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11) Recommended duration of reasonable accommodation: ____________________

12) Additional information to support need for reasonable accommodation: ____________

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Physician's Printed Name	Degree	License Number
Physicians's Signature Date	Address	Phone

Employees/applicants are responsible for having this form completed and forwarded to your supervisor.