Illinois AmeriCorps Disability Outreach Project
MEDICAL REVIEW FORM

The Serve Illinois Commission is requesting disclosure of information that is necessary to assist in evaluating a reasonable accommodation request. Disclosure of this information is VOLUNTARY.

Member/ Applicant Name: _____ Date of Birth: _____
Home Address: _____ State: _____ Zip: _____
Social Security Number: _____
Program Name: _____
Contact Name: _____ Address: _____

Member/ Applicant's disability: _____
(including a physical or mental impairment that substantially limits one or more major life activities, which include such things as caring for oneself, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, breathing, learning, and working)

Major life limitation (s): _____

What are the specific essential job functions this person cannot perform without a reasonable accommodation due to the disability? _____
_____

What type of reasonable accommodation do you suggest for the member/ applicant? _____
_____
_____

What, if any, alternative accommodation(s)? _____
_____

Recommended duration of reasonable accommodation: _____

Additional information to support need for reasonable accommodation: _____
_____
_____

Physician's printed name: _____
Degree: _____ License Number: _____
Address: _____ Telephone Number: _____

_____ _____
Physician's signature: Date:

**Members/applicants are responsible for having this form completed by Physician and forwarded to your Program Director.*