The Community Partnership
For the Prevention of Homelessness

Date: ____

Subject: **CONFIRMATION OF REASONABLE ACCOMMODATION REQUEST**

Dear: ____:

On ______________________________, your service provider ______________________________________
informed me that you are seeking a reasonable accommodation to:
____.
This letter serves to confirm that request.

The Community Partnership and the Department of Human Resources is committed to providing reasonable accommodations to its consumers and providers to ensure that individuals with disabilities enjoy equal access to all opportunities. To better respond to your request, we require additional information from your treating physician.

There are several important documents included with this correspondence. They include: (1) Our Reasonable Accommodation Request Confirmation and (2) A Medical Questionnaire.

Please share this entire packet with your medical care provider and have them to complete the medical questionnaire. Please return the completed questionnaire to me. A response will be provided within 15 days of receipt of the completed questionnaire.

If you have any questions regarding this process, please do not hesitate to contact me. You may call me at (202) 543-5298 or by email at CCoates@Community-partnership.org.

Sincerely,

____

Candyce Coates
Program Officer
The Community Partnership

The Community Partnership
For the Prevention of Homelessness

Date:____

MEDICAL QUESTIONNAIRE FOR REASONABLE ACCOMMODATION REQUEST

To the physician:

Your patient, ___________________________ indicated that she/he needs ____. We need additional information from his/her treating care provider to properly address this reasonable accommodation request.

Complete this questionnaire relating to your patient. **Please type your answers on your official letterhead.**

1. State the diagnosis and history of the medical (including psychological, if applicable) condition.

2. State the current status of the condition, including clinical findings from physical and mental examination, laboratory tests and other pertinent data.

3. State the patient's prognosis, including plans for future treatment and an estimate of the date of full or partial recovery.

4. State your clinical assessment of risk of injury, or hazard to the patient of others that may arise from the performance of the work requirements outlined in the attached Position Description for [NAME OF POSITION].

5. Identify the following major life activities that are affected by the patient's medical condition, if any.

- ☐ Breathing
- ☐ Caring for Self
- ☐ Concentrating
- ☐ Controlling Bowels
- ☐ Eating
- ☐ Hearing
- ☐ Interacting w/Others
- ☐ Learning
- ☐ Lifting
- ☐ Manual Tasks
- ☐ Reaching
- ☐ Reproduction
- ☐ Running

- ☐ Seeing
- ☐ Sexual Function
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Walking
- ☐ Working
- ☐ Working

6. Describe what the patient cannot do, as well as what she/he is able to do and compare his/her abilities/limitations of the average person.

7. For each major life activity checked in Number 5 above, please state whether the patient significantly is restricted in his or her ability to perform the activity as compared to the average person and describe how the patient is significantly restricted as compared to the average person for each of the major life activities that applies. For example, if the average person has 20/20 vision but the patient has 240/300 vision, please state how that difference significantly restricts the patient's ability to see as compared to the average person. If the patient is not significantly restricted in any major life activity that you have checked, please so state.

8. How long is the condition expected to last?

9. What accommodations, if any, do you recommend for this patient in order to perform the work requirements in number 4 above?

The responses to this questionnaire should be typed on the treating care provider's letterhead and signed by the treating care provider. If the patient has any questions, they may be directed to the ADA Coordinator, Candyce Coates, at ccoates@Community-partnership.org or (202) 543-5298.

The requestor must return the physician's answers to this questionnaire to:

Candyce Coates
The Community Partnership for the Prevention of Homelessness
801 Pennsylvania Ave. S.E.
Washington, DC 20003
(202) 543-5298 (office)
(202) 543-5653 (fax)
CCoates@community-partnershipr.org

MEDICAL QUESTIONNAIRE FOR REASONABLE ACCOMMODATION REQUEST

(CONT.)

1. Employee Name Employee Phone No.
   Request Date Employee's Office

2. TYPE OF ACCOMMODATION REQUESTED

3. REASON FOR REQUEST

Privacy Statement

The Rehabilitation Act of 1973, 29 U.S.C. section 791, authorizes the collection of this information. The primary use of this information is to consider, decide, and implement requests for reasonable accommodation. Additional disclosures of the information may be: To medical personnel to meet a bona fide medical emergency; to another District agency, a court, or a party in litigation before a court or in an administrative proceeding ; being conducted by a District agency when the District is a party to the judicial or administrative proceeding; to a legislative office from the record of an individual in response to an inquiry from the legislative office made at the request of the individual; and to an authorized grievance official, administrative judge, equal employment opportunity investigator, arbitrator or other duly authorized official engaged in investigation or settlement of a grievance, complaint or appeal filed by an provider.