[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Dear [Employee Name],

We are writing to follow up on your recent request for a workplace accommodation under the Americans with Disabilities Act (ADA). To better understand how we can support you and to determine the appropriate next steps, we require additional information from your healthcare provider.

Attached to this letter is a "Medical Certification Form." Please have your treating physician or qualified healthcare professional complete this form and return it to [Department Name/Person Name] by [Date].

The purpose of this documentation is to confirm:

- Whether you have a physical or mental impairment that limits one or more major life activities.
- How your condition affects your ability to perform the essential functions of your job.
- Suggestions for specific accommodations that would enable you to perform those functions.

Please note that we are not seeking your entire medical record or a specific diagnosis. We only require information relevant to your request and your ability to perform your job duties.

All medical information provided will be kept confidential and stored in a file separate from your personnel record, in accordance with ADA requirements.

If you have any questions regarding this request or the attached form, please contact [Name] at [Phone Number] or [Email Address].

Sincerely,

[Your Name]
[Your Title]
[Company Name]

Enclosure: Medical Certification Form