Date: [Insert Date]

To: [Insert Healthcare Provider Name]
[Insert Healthcare Provider Address]
[City, State, Zip Code]

Re: Medical Documentation for Disability Accommodation
Patient Name: [Insert Employee Name]
Date of Birth: [Insert Date of Birth]

Dear [Insert Doctor Name],

I am writing to request medical documentation regarding a physical disability that requires workplace accommodations. I have authorized the release of this information to my employer, [Insert Company Name], to assist in the interactive process under the Americans with Disabilities Act (ADA).

Please provide a written statement or complete the attached form addressing the following points:

- A description of the physical impairment and how it limits my ability to perform major life activities.
- How the impairment interferes with my ability to perform the essential functions of my job, which include: [Insert Key Job Tasks].
- Specific recommendations for accommodations that would enable me to perform these duties (e.g., ergonomic equipment, modified schedule, lifting restrictions).
- The expected duration of the need for these accommodations.

Please do not provide my full medical history or genetic information. Focus only on the functional limitations relevant to my job requirements.

You may provide this documentation directly to me or send it to the Human Resources department at [Insert HR Email/Address].

Thank you for your assistance.

Sincerely,

[Insert Signature]
[Insert Printed Name]
[Insert Phone Number]