

REASONABLE ACCOMMODATION HEALTH CARE PROVIDERRELEASEORM

(THIS FORM TO BE COMPLETED BY THE EMPLOYEE/APPLICANT)

Complete this form to authorize your Health Care Provider to disclose information related to your request. Submit this completed form to your certified Health Care Provider, along with copies of the Reasonable Accommodation Request Form and the Health Care Provider Statement Form.

SECTION 1 APPLICANT/EMPLOYEE INFORMATION	
Name:	DOB:
Address:	Phone #:
	Email:
SECTION 2- HEALTH CARE PROVIDERIFORMATION	
Name:	
Practice/Specialty:	
Address: F	Phone #: