

[Your Name]
[Your Title/Department]
[Organization Name]
[Date]

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

Subject: Request for Additional Disability Verification Documentation

Dear [Employee/Applicant Name],

We have received your initial request for a workplace accommodation. After reviewing the information provided, we find that we require additional documentation to better understand your functional limitations and to determine the most effective reasonable accommodation.

To process your request, please have a qualified healthcare provider provide the following information:

- A description of the nature of the impairment.
- The duration of the impairment (permanent or temporary).
- How the impairment limits your ability to perform essential job functions.
- Specific suggestions for accommodations that would enable you to perform these functions.

Please submit the requested documentation to [Department Name] by [Date]. You may use the attached form to facilitate this request with your healthcare provider.

All medical information will be kept confidential in accordance with applicable privacy laws and will be maintained in a separate file from your general personnel records.

If you have any questions, please contact me at [Phone Number] or [Email Address].

Sincerely,

[Your Signature]
[Your Printed Name]