**[Use Agency’s letterhead]**

Date (Month Day, Year)

Private Physician’s Name

Address 1

Address 2

City, State Zip

RE: **Requirement for Medical Evaluation of (Employee’s Full Name) by Private Physician or Practitioner**

Dear (Private Physician’s or Practitioner’s Name):

The District government is committed to ensuring a safe and secure workplace where all employees can perform the essential functions of their position, with or without reasonable accommodation(s). Your patient is employed with the (Employing Agency) in the position of (Position Title). Recently, there has been concern regarding your patient’s continuing ability to carry out the essential functions of their position:

* [Describe the observations or issues in an enumerated and chronological list (ex. emails, performance reviews, etc.).]

As [employee name] private physician/practitioner, we are seeking your opinion in order to make decisions regarding their work status and duty assignments.

We request that you use the enclosed form to recommend the appropriate work status for the employee. Please refer to the attached position description for a list of the employee’s essential functions. In addition to the duties outlined in the position description, the following are additional essential duties that [Employee’s Name] must perform:

* Document the essential duties that the employee must perform that are not in the position description;
* Document all essential duties that the employee has had issues performing or has been unable to perform; and
* If necessary, please identify what physical or mental requirement(s) are needed to perform the essential duties of the position. These requirements should highlight the observed deficiencies that the employee has exhibited, where possible.

We are requesting that you examine your patient and provide (Employing Agency Representative’s Name), (Position Title), with the (Agency), with the information enclosed and your recommendation on whether the employee can perform the essential duties of their position, with or without accommodation(s).

To the extent that you medically determine that your patient requires accommodation(s) to perform the essential functions of their position or should be restricted from certain or all functions, please specify the nature and scope of the accommodations and/or restrictions. Please also specify how long the restriction(s)/accommodation(s) should apply. [*Please note that an accommodation does not include eliminating any of the essential functions of the position, but rather providing assistance or tools to assist the employee in performing the essential functions of their position.]*

If you do not specialize in occupational medicine, we encourage you to seek the opinion of an occupational physician or practitioner prior to making your recommendation. If necessary, the District government can arrange for you to consult with its contracted vendor who specializes in occupational medicine.

Thank you for your cooperation in resolving this matter. Should you have any questions, please contact (Employing Agency Representative’s Name) at (Telephone Number).

Sincerely,

Agency Head (or Designee)

Enclosures:

(1) Physician’s or Practitioner’s Work Status Recommendation

(2) Position Description