ADA Documentation Request:
Order to Wear Non-Medical Face Coverings

Limited Release of Medical Center Information:

My signature below indicates my limited release of medical information to my employer, _____, as requested in this letter and is necessary to assess the availability of reasonable accommodation to me at work.

_____ _____ _____
Employee's Printed Name Employee's Signature Date

Date: _____

Doctor's Name: _____

Doctor's Address_____
Address City State Zip

Re: _____
Employee Name Position

Dear Dr. _____,

Employer and _____ ask for you to examine _____
Employee Name Employee Name
for the purpose of determining if _____ cannot medically tolerate a face
Employee Name
covering and should be deemed exempt from the requirements of wearing a face mask. Please answer the following questions:

1. _____ is currently employed as _____.
   Employee Name Job Title

   To best help you understand _____ job for purposes of assessing his or
   Employee Name
   Her capabilities and limitations, please see the attached job description.

2. Does _____ have a medical condition that would prevent him or her
   Employee Name
   from medically tolerating a face covering? ☐ Yes ☐ No

   a. If yes, which type of face covering would he or she be prevented from wearing?
      1. ☐ Face Mask
      2. ☐ Face Shield
      3. ☐ Employee would not be able to medically tolerate **any** type of face covering.

   b. If the employee would not be able to medically tolerate any type of face covering, can you identify a reasonable accommodation that may enable _____
      Employee Name
      to perform the essential functions of his or her job?

Examples of potential accommodation include working in a secluded area or working from home.

_____

_____

_____

_____

_____

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_____

c. If working in a secluded area is a potential accommodation, would the employee be able to wear a mask for a short period of time such as walking through the halls to/from enter/exit the building and to/from the restroom? ☐ Yes ☐ No

Thank you for your professional attention to this matter. Please assist us further by signing below to indicate that you have personally evaluated _____ and reviewed the attached job description.
Employee Name

_____ _____

Health Care Provider Signature Date

_____

Print Name and Title