



PURPOSE: The interactive process for reasonable accommodation is activated when employees present medical conditions that may impact one’s ability to be at work, stay at work, and perform the work. Guidance for this process is available through the **Americans with Disabilities Act (ADA)**, the **California Fair Employment and Housing Act (FEHA)** and the **Job Accommodation Network (JAN)**. Refer also to this website.

Questions that require medical clarification develop when an employee’s prognosis for being at work, staying at work, or performing the work are unclear or in conflict among medical providers. Concern may also develop about the risk of further harm to an employee or others when returning | performing the work (referred to as “direct threat” under the ADA). Evaluation of accommodation options includes the Employer's right and responsibility to refer an employee for independent medical evaluation through a 'Fitness for Duty' at the employer's expense. Authorization for such an exam is derived from California Government Code §12940(f)(2) and under the Americans with Disabilities Act (ADA) for employment-related inquiries.

Dr. Debra Dupree assists the employer and employee in seeking medical guidance so that informed decisions are achieved. Dr. Dupree represents an independent disability management consultant | mediator process. Confidential information obtained may be shared with those engaged in the interactive process. Any medical reports and/or diagnoses received by Dr. Dupree and/or her associates are not disclosed to the employer or any other party for use in the interactive accommodation process.

This is in accordance with the Confidentiality of Medical Information Act of 1981, Section 56, et seq., of the California Civil Code and the HIPAA Privacy Rule. Strict confidentiality of medical information is maintained and **used only for the purpose of the reasonable accommodation process.**

A. CONSENT TO EXCHANGE by Employee:

Employee: _____, Date of Birth: _____, last four digits of SS#: _____,

Employer: _____, CLAIM # _____ (if applicable), DOI: _____.

B. AUTHORIZE: _____ or _____ Phone #:

Email

Fax #:

C. I UNDERSTAND that I have the right to limit the type of information to be released to Dr. Dupree. as checked below:

- Return to work status updates
- Maximum Medical Improvement (MMI) or Permanent and Stationary (P&S) Report
- Response to Dr. Dupree’s correspondence and medical questionnaire

NOTE: This consent does not include release of any and/or all reports that detail medical history or diagnosis. Consent applies ONLY to information related to the medical condition requiring work-place accommodation(s).

DURATION: This consent becomes effective immediately and shall remain in effect for up to 90 days from the date listed below.

D. LIMITATIONS: I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

E. EMPLOYEE’S SIGNATURE:

F. SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____