MEDICAL QUESTIONNAIRE IN SUPPORT OF ACCOMMODATION REQUEST

The purpose of this form is to make a determination about whether an employee has a disability that qualifies for an accommodation consistent with the Americans with Disabilities Act (ADA) and must be completed by the treating medical provider. The ADA provides for reasonable accommodations for qualifying employees to perform the essential functions of their jobs and also provides reasonable accommodations for other benefits and privileges of employment (e.g. training development, recognition activities). Not all requests for accommodations require a completed medical questionnaire (e.g. when both the disability and need for accommodation are obvious or when the employee has already provided sufficient information to document the existence of the disability and functional limitations relating to the essential functions of the job).

Employee Name: _____

1. Have you examined employee? **Yes** ☐ **No** ☐
   If YES, date of last Examination: _____

2. Does the employee have a "physical or mental" impairment interfering with the employee's ability to perform the essential functions of the job or access a benefit or privilege of employment? **Yes** ☐ **No** ☐
   (The ADA defines "physical or mental impairment" as any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin and endocrine and any mental or psychological disorder, such as intellectual disability (formerly termed mental retardation), organic brain syndrome, emotional or mental illness, and specific learning disabilities. This list of examples is not exhaustive).

3. Does the physical or mental impairment impact any "major life activity" of the employee?
   Yes ☐ **No** ☐
   (The ADA defines "major life activities" as the basic activities that the average person in the general population can perform with little or no difficulty, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, and reaching. Major life activities also include the operation of major bodily functions including but not limited to immune, normal cell growth, digestive, bowel, bladder, genitourinary, hemic, special sense organs and skin, lymphatic, neurological, brain, respiratory, circulatory, endocrine, reproductive, musculoskeletal, special sense organs, cardiovascular. This list of examples is not exhaustive).

   a. If you answered YES to #3, please identify the specific major life activity/activities impacted:

4. With respect to a major life activity identified in your response to #3a OR the activity of working if you answered YES to #3b, is the employee **substantially** limited in such activity?
   Yes ☐ No ☐

   ("Substantially limited" means the employee is unable to perform the activity, or substantially limited in the manner or duration under which he/she can perform the activity, as compared to the ability or the average person in the general population).
   - Compare the employee to most people in the general population.
   - The impairment need not prevent or severely restrict.
   - Consider the limitation as if the condition is in active state. Mitigating measures should not be considered. (e.g. medication, medical equipment and devices, prosthetic limbs, low vision devices, hearing aids, mobility devices)

5. Is the substantial limitation temporary or permanent? _____ (Note: Does not need to significantly or severely restrict to meet this standard.) If temporary, what is the anticipated duration of the impairment? _____

6. Can the employee perform the essential functions of the position WITH a **Reasonable Accommodation**? (See attached description of essential job function). **Yes ☐ No ☐**
   a. If you answered YES to #6:
      i. Which job functions require an accommodation?

      ii. What accommodation(s) is/are recommended?

      iii. How will the accommodation(s) enable the employee to perform the essential functions of the position or access a benefit or privilege of employment?

_____ _____
Signature of Medical Provider Date

Provider's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

_____ _____
Employee Signature Date