# [1]MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

**Print Employee Name:** _____ **Banner ID: 000**_____

Your patient has requested an accommodation related to their position with our organization, which may qualify under the Americans with Disabilities Act (ADA) as a reasonable accommodation. **Please complete this form and email it to your Human Resources Consultant.**

**A. Questions to help determine whether an employee has a disability.**

Under ADA, an employee has a disability if he or she has physical or mental impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability:

| | | |
|---|---|---|
| Does the employee have a physical or mental impairment? | Yes, Permanent impairment(s) ☐<br>Yes, Temporary Impairment(s) ☐ | No ☐ |

If *yes*, what is the impairment or the nature of the impairment?

If you indicated the employee has a temporary impairment, please indicate the anticipated length of time until the employee is no longer temporarily impaired?

Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used.

- Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy.
- Mitigating measures *<u>do not</u>* include ordinary eyeglasses or contact lenses.

| | | |
|---|---|---|
| Does the impairment substantially limit a major life activity as compared to most people in the general population?<br><br>*Note: Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.* | Yes ☐ | No ☐ |
| | OR<br><br>Describe the employee's limitations when the impairment is active. | |

If *yes*, what major life activity(s) (includes major bodily functions) is/are affected?

| | | | | |
|---|---|---|---|---|
| ☐ Bending | ☐ Hearing | ☐ Reaching | ☐ Speaking | ☐ Other: (describe) |
| ☐ Breathing | ☐ Interacting With Others | ☐ Reading | ☐ Standing | |
| ☐ Caring For Self | ☐ Learning | ☐ Seeing | ☐ Thinking | |

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☐ Concentrating ☐ Lifting ☐ Sitting ☐ Walking
☐ Eating ☐ Performing Manual Tasks ☐ Sleeping ☐ Working

Major bodily functions:

☐ Bladder ☐ Digestive ☐ Lymphatic ☐ Reproductive
☐ Bowel ☐ Endocrine ☐ Musculoskeletal ☐ Respiratory
☐ Brain ☐ Genitourinary ☐ Neurological ☐ Special Sense Organs & Skin
☐ Cardiovascular ☐ Hemic ☐ Normal Cell Growth ☐ Other: (describe)
☐ Circulator ☐ Immune ☐ Operation of an Organ

**Will the impairment, including residual effects, last several months?**

| Yes ☐ | No ☐ |
|---|---|

**If the impairment will not last several months, please describe the severity of the impairment.**

_____

**Is there reason a reason to believe that the patient's condition will improve significantly over time, allowi the patient to return to work?** Yes ☐ No ☐

**B. Questions to help determine whether an accommodation is needed.**

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested (or a different) accommodation (including those that may mitigate the requested absence) is needed because of the disability.

Talk with your patient about the job functions he/she typically performs to answer the following questions:

| | |
|---|---|
| Are job functions impeded? Do the limitations to major life activities indicated above impede or prevent your patient from performing his/her job functions? | ☐ Yes<br>☐ No |

If yes, which job functions are impeded by the limitation? Which job functions is the patient unable to perform, or which benefits of employment are inaccessible without accommodation?

If yes, how are job functions impeded by the limitation? In what way(s) do the patient's limitation(s) impede his/her ability to perform typical job function(s) or access benefits of employment?

**C. Questions to help determine effective accommodation options.**

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

Do you have any suggestions, other than time away from work, regarding possible accommodations to enable performance of job functions? Yes ☐ No ☐

If yes, what are they?

If the patient's employer were able to accommodate the above restriction(s) or provide an accommodation to the patient's current role, would the patient be able to return to work. Yes ☐ No ☐

If so, please list the date your patient could return to work: _____(mm/dd/yyyy)

How would your suggestions improve the patient's ability to perform the job functions?

Will your patient have work restrictions upon returning to work? Yes ☐ No ☐

If yes, please describe the restrictions and indicate how long each restriction will continue:

**D. Complete Part D if patient is requesting leave as an accommodation:**

Frequency of Absence: Will the absence be taken in an uninterrupted block of time OR in occasional absences?

☐ Uninterrupted block of time (i.e. continuous) **Complete part D1**

☐ Occasional absences (i.e. intermittent or reduced schedule) **Complete part D2**

Part D1 – If this leave is continuous:

Start Date: Please indicate start date of continuous leave: _____ (dd/mm/yyyy)

End Date: On what date do you expect the patient to return to work? _____ (dd/mm/yyyy)

How confident are you that the patient will return to work on that date?

☐ Definitely will return to work on the date above.
☐ Very likely will return to work on the date above.
☐ Possibly will return to work on the date above.
OR
☐ I cannot provide an estimate on when my patient will return to work. If so, please explain:

Part D2 – If this leave is occasional:

## ☐ Intermittent Leave:

Is the patient able to work but needs occasional time off as an accommodation?

Start date for leave or initial appointment date:

____/_____/_____(mm/dd/yyyy)

Probably end date for leave:

____/_____/_____(mm/dd/yyyy)

*Or*

☐ Condition is lifelong (check if applicable)

**Appointments/treatments** – Will the patient need to miss work for appointments or treatments?

*No* ☐

Yes ☐ - Estimate Treatment Schedule:

Frequency: Up to ____*times per:* ☐week ☐ month ☐ year

Duration for each: Up to ____ ☐hours ☐ days

Please include the dates of any scheduled appointments and the time required for each:

_____

**Flare-ups/Episodes**: Will the patient's condition present in recurring flare-ups or episodes? How often and for how long?

No ☐
Yes ☐ - Provide estimates:

Frequency: Up to ____times per*:* ☐week ☐ month ☐ year

Duration for each: Up to ____ ☐hours ☐ days

## ☐ Reduced Scheduled Leave

Is the patient able to work but needs a FIXED part-time schedule or taking predictable regularly scheduled absences as an accommodation?

Start date for leave or initial appointment date:
____/_____/_____(mm/dd/yyyy)

Probably end date for leave:

____/_____/_____(mm/dd/yyyy)

Please indicate the amount of hours the patient will need to miss each day. Enter"0" for any days that your patient does work but will not need a reduced schedule.

| | | |
|---|---|---|
| Sun | _____hours off | ☐ Not scheduled to work |
| Mon | _____hours off | ☐ Not scheduled to work |
| Tu | _____hours off | ☐ Not scheduled to work |
| Wed | _____hours off | ☐ Not scheduled to work |
| Th | _____hours off | ☐ Not scheduled to work |
| Fri | _____hours off | ☐ Not scheduled to work |
| Sat | _____hours off | ☐ Not scheduled to work |

Medical Professional's Signature Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.