

## SAMPLE MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

### Notes on usage for Commonwealth Agencies:

- This request is to be used only when the employee's disability is not obvious to the casual observer.
- The employee must be given the option to make the request directly to the physician.
- Include with this request a copy of the employee's job description (Form 30).
- The employee must be given a copy of "[What to Expect When Requesting Reasonable Accommodation](#)." [Note: This document can only be accessed when logged on to a Commonwealth PC or a remote account]

**Employee Name:** \_\_\_\_\_.

### To be completed by the employee:

#### A. Questions to help determine the nature of the request.

A reasonable accommodation is any change in the work environment that helps an employee perform the essential functions of their job or to enjoy the benefits and privileges of employment. To be eligible for a reasonable accommodation you must establish the connection between your disability related limitations and the specific request you are making. If you have a disability that limits the ability to do the essential/core functions of your job, your employer must provide a reasonable accommodation, unless the accommodation requested poses an undue hardship. Additionally, once an accommodation has been provided you must be capable of performing the essential functions of your job.

**1. What limitation(s) due to a disability do you have that interferes with your job performance?**

**2. What job functions are you having trouble performing because of the limitation(s)?**

**3. Describe how this limitation(s) interferes with your ability to perform the job function(s)?**

### To be completed by the medical provider:

You have been asked to complete this form on behalf of your patient who requested a disability related workplace accommodation from their employer. The employer seeks verification that your patient has: 1) a disability as defined by the ADA (See B below) and that: 2) their disability results in the functional limitations described in A above (See C below).

#### B. Questions to verify disability.

For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities. The following questions may help determine whether the employee has a disability as defined by the ADA.

**Note:** The questions should be answered 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, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

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 provided 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.

**According to the ADA, major life activities may include but are not limited to:**  
This is for information purposes only – **do not circle**. This will be used to answer the question below.

Caring for Self	Walking	Hearing	Lifting	Bending
Interacting With Others	Standing	Seeing	Sleeping	Reading
Performing Manual Tasks	Reaching	Speaking	Concentrate	Eating
Breathing	Thinking	Learning	Reproducing	Working
Toileting	Sitting	Communicating		

1. Does the employee have a physical or mental impairment that substantially limits a major life activity? <i>Note: Does not need to significantly or severely restrict the life activity to meet this standard.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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**According to the ADA, major bodily functions may include but are not limited to:**  
This is for information purposes only – **do not circle**. This will be used to answer the question below.

Immune	Genitourinary	Brain	Musculoskeletal
Normal Cell Growth	Hemic	Respiratory	Cardiovascular
Digestive	Special Sense Organs or Skin	Circulatory	Reproductive
Bowel/Bladder	Lymphatic	Endocrine	Neurological

2. Does the impairment substantially limit the operation of a major bodily function? <i>Note: Does not need to significantly or severely restrict the bodily function to meet this standard.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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**C. Verification of functional limitation(s).**

1. Does your patient have the functional limitation(s) described in A-1?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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2. Is the functional limitation due to their disability?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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3. What is the anticipated duration of the impairment?	
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**D. Comments:**  
Employers are obligated to make reasonable accommodations to allow their employees with disabilities the opportunity to perform the essential functions of their job provided the requested accommodation does not fundamentally alter the nature of the job or result in an undue administrative or financial burden.  
In order to help us work with our employee, do you have suggestions on accommodations that might be provided?  
Note: Your suggestions will be used in the interactive process with the employee. The specific accommodation you suggest may or may not be the accommodation ultimately provided.

**E. Medical Professional Information and Signature.**

Name:		License:	
Address:		City / State / Zip Code:	
Medical Professional's Signature: \S\		Date:	