



Medical Inquiry Form / Accommodation Request

Employee Name: _____

Date: _____

Job Evaluated: _____

Please answer and return the following questionnaire as soon as possible. A self-addressed, stamped envelope is enclosed for your convenience. The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions, if needed, to answer more fully. Thank you for your anticipated cooperation.

IMPORTANT NOTE TO HEALTH CARE PROVIDER: When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

1. Does the employee have a physical or mental impairment? {circle one} Yes No

If so, please state the diagnosis code and type of impairment: _____

2. Does the employee's impairment substantially limit any of his/her major life activities? {circle one} Yes No

If so, which major life activity or activities are limited? _____

3. For each major life activity that is limited by the impairment, please describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity: _____

4. What is the duration or expected duration of the employee's impairment? _____

5. Attached is a job description for the employee's position. In addition to the attached job description, essential functions of this position also include the following:

_____ Being available and able to complete all required essential functions and assigned job tasks during the company's normal business hours of 8:00 a.m. – 5:00 p.m.

_____ Consistent and timely attendance.

_____ Other:

**Once you have reviewed the job description and the list of additional, specific job functions above, please assess whether the employee can perform all of these job functions and explain below which functions, if any, s/he is not able to perform:

