MEDICAL INQUIRY FORM
RESPONSIVE TO ACCOMMODATION REQUEST

FOR COMPLETION BY EMPLOYEE

Employee’s Name: _______________________________________

Authorization for Release of Medical Information

I authorize my Healthcare Provider to release medical information that is specifically related to and necessary for my employer to determine whether I have a disability for which an accommodation(s) may be needed. I authorize my Healthcare Provider to speak directly to my Agency ADA Coordinator in regards to my medical condition and its effects upon my ability to perform the essential functions of my job. I understand that I may refuse to sign this Authorization. However, I understand that my failure to permit these disclosures may impact my employer's ability to fully address my request for accommodation.

Employee’s Signature:  _____________________________________________ Date:  _______________

FOR COMPLETION BY HEALTHCARE PROVIDER

SECTION 1: Questions to determine whether employee has a disability

For reasonable accommodation under the Americans with Disabilities Act (ADA), an employee has a disability if he/she has an impairment that substantially limits one or more major life activities or has a record of such an impairment. The following information may help to determine whether an employee has a disability:

Does the employee have a physical or mental impairment?

[ ] Yes (proceed to section A. below)  [ ] No (discontinue completion of form)

A. What is the impairment or the nature of the impairment? _____________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

B. Does the impairment substantially limit a major life activity as compared to the general population?

[ ] Yes  [ ] No

C. What major life activity(s) and/or major bodily function(s) is limited?

**Major Life Activities:**
- Bending
- Breathing
- Caring for Self
- Concentrating
- Other:
- Eating
- Hearing
- Interacting with Others
- Learning
- Lifting
- Performing Manual Tasks
- Reaching
- Reading
- Seeing
- Sitting
- Sleeping
- Speaking
- Standing
- Thinking
- Walking
- Working

**Major Bodily Functions:**
- Bladder
- Bowel
- Brain
- Cardiovascular
- Circulatory
- Digestive
- Endocrine
- Genitourinary
- Hemic
- Immune
- Lymphatic
- Musculoskeletal
- Neurological
- Normal Cell Growth
- Operation of an Organ
- Reproductive
- Respiratory
- Special Sense Organs & Skin
D. Describe any functional limitations caused by the impairment:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

SECTION 2: 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 information may help determine whether the requested accommodation is needed because of the disability:

A. What job duties is the employee unable to perform or having difficulty performing?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

B. How does the employee’s functional limitation(s) interfere with his/her ability to perform required job duties?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Health Care Provider’s Signature: ___________________________ Date: __________

Health Care Provider’s Name (Printed): ___________________________
Practice Specialty: ___________________________
Clinic Name: ___________________________
Address: ____________________________________________________________
Telephone #: ___________________________ Fax #: ___________________________

RETURN COMPLETED FORM DIRECTLY TO Veronica M. Biscoe, AGENCY ADA COORDINATOR
By Fax to: (318) 357-5299; or, email to: ramirezv@nsula.edu