

**MEDICAL INQUIRY FORM
RESPONSIVE TO ACCOMMODATION REQUEST**

FOR COMPLETION BY EMPLOYEE

CONFIDENTIALITY STATEMENT:
A request for accommodation, including medical and other relevant information, is privileged and may only be released as appropriate to individuals with a business need to know.

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:

- | | | | | |
|--|--|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Eating | <input type="checkbox"/> Lifting | <input type="checkbox"/> Seeing | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Hearing | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Sitting | <input type="checkbox"/> Thinking |
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Interacting with Others | <input type="checkbox"/> Reaching | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Learning | <input type="checkbox"/> Reading | <input type="checkbox"/> Speaking | <input type="checkbox"/> Working |
| <input type="checkbox"/> Other: _____ | | | | |

Major Bodily Functions:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Circulatory | <input type="checkbox"/> Hemic | <input type="checkbox"/> Neurological | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Digestive | <input type="checkbox"/> Immune | <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Special Sense |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Operation of an Organ | Organs & Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Reproductive | |

Other: _____

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