Patient Name: _____ DOB: _____

SECTION IV: MEDICAL INQUIRY FORM (TO BE COMPLETED BY PHYSICIAN)

MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

Completed forms are to be returned to the Office of Compliance
oc-hsc@uthsc.edu | fax (901) 448-1120 | 920 Madison, Suite 825 Memphis, TN 38163
*Providers may attach relevant documents to this form.

A. Questions to help determine whether an employee has a 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 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 ☐ No ☐

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

_____

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 do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population? Yes ☐ No ☐

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.*

OR

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	_____
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	_____
☐ Eating	☐ Performing Manual Task	☐ 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)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	_____

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 accommodation is needed because of the disability:

What limitation(s) is interfering with job performance or accessing a benefit of employment?

_____

_____

What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?

_____

_____

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit 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 regarding possible accommodations to improve job performance? If so, what are they?

_____

_____

How would your suggestions improve the employee's job performance?

_____

_____

D. Other questions or comments.

_____

_____

E. Signature

_____ _____
Medical Professional's Name and Signature Date

_____ _____
Medical Professional's Contact Information Clinic Name