

Appendix E: REASONABLE ACCOMMODATION MEDICAL QUESTIONNAIRE

EMPLOYEE/PATIENT'S NAME: _____

EMPLOYEE/PATIENT'S WORK SCHEDULE: _____

Dear Medical Professional,

A request for a reasonable accommodation has been made by our employee, who is listed above. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please be as specific as possible.

Background

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. **"Substantially limits" under the ADAAA has been broadened to allow** someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or *expected* duration less than or equal to six months.

The ADAAA provides examples of "**major life activities**," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

Please answer these questions to help determine disability and reasonable accommodation.

1) Does the employee have a physical or mental impairment?

If yes, what is the impairment?

Please indicate date impairment commenced.

Please indicate if impairment comes and goes or is episodic in nature, and, if so, for what period of time do symptoms occur?

2) What limitation(s) is interfering with the employee's job performance, and how does it interfere with the employee's ability to perform the essential job function(s)?

3) Is a major life activity substantially limited by this impairment?

If yes, what activity is substantially limited?

4) What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

5) The employee's typical schedule is listed on the first page. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?

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

- 7) Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?

Yes/No

If *yes*, please continue to next question.

If *no*, how long will the employee be unable to perform these job duties?

_____ # of weeks _____ # of months _____ permanently

- 8) How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?

By signing below, I certify that the patient named herein is my patient and the information provided herein is based on my knowledge of his/her physical or mental impairment.

Medical Professional Name (Please Print): _____

Type of Practice/Specialty: _____

Address: _____

Phone: _____

Fax: _____

Signature of Medical Professional completing form

Date

ONCE COMPLETE PLEASE RETURN THIS DOCUMENT TO YOUR PATIENT OR
FAX IT TO THE KC HUMAN RESOURCES DEPARTMENT AT (903) 983-8609.