**Medical Inquiry for Reasonable Accommodation Requests**

**under**

**The Americans With Disabilities Act (ADA)**

**or Applicable State or Local Law**

**[TO BE FILLED OUT BY HEALTH CARE PROVIDER]**

*Please Complete and return to: LuzSelenia Salas, Employee Relations, lsalas@philasd.org*

|  |  |
| --- | --- |
| Employee Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Print Name) | Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Building/Location:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Questions to help determine whether an employee has a disability.

1. Does the employee have a physical or mental impairment as defined by the ADA? Yes ❒ No ❒
2. What is the impairment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is the impairment long-term or permanent? Yes ❒ No ❒
4. If not permanent, how long will the impairment likely last?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the impairment limit the employee’s ability to engage in any life activities? Yes❒ No❒
2. If “yes,” please indicate which activities (please circle all applicable responses):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Caring for Self | Walking | Hearing | Lifting | Other: (Please describe) |
| Interacting with Others | Standing | Seeing | Sleep | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Performing Manual Tasks | Reaching | Speaking | Concentrating | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Breathing | Thinking | Learning | Reproduction | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Working in a Class of Jobs | Toileting | Sitting | Eliminating Bodily Waste | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Please provide a thorough description of how and the extent to which the impairment limits the activity or activities circled above. Attach additional pages if necessary.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

**Questions to help determine whether an accommodation is needed.**

1. What job function(s) is the employee having difficulty performing because of the limitation(s) described in questions 5, 6, and 7 above?

|  |
| --- |
|  |
|  |
|  |

1. How does the employee’s limitation(s) interfere with his/her ability to perform the job functions(s) identified in response to question 8?

|  |
| --- |
|  |
|  |
|  |

1. What benefits/privileges of the workplace can the employee not enjoy because of the limitations described in questions 5, 6, and 7 above?

|  |
| --- |
|  |
|  |
|  |
|  |

11. How do(es) the employee’s limitation(s) prevent the employee from enjoying the benefits/privileges of the workplace identified in the response to question 10?

|  |
| --- |
|  |
|  |
|  |
|  |

**Questions to help determine effective accommodation options.**

12. Do you have any suggestions regarding possible accommodations to assist the employee to perform the job function(s) that (s)he is having difficulty performing and/or allow him or her to enjoy the benefits/privileges of the workplace identified in question 10?

Yes ❒ No ❒

13. What are those suggestions?

|  |
| --- |
|  |
|  |
|  |
|  |

14. Please describe how your suggestions would assist the employee in performing the job functions that (s)he is having difficulty performing as identified in question 8 and/or allow him or her to enjoy the benefits/privileges of the workplace identified in question 10?

|  |
| --- |
|  |
|  |
|  |
|  |

Additional Comments:

|  |
| --- |
|  |
|  |
|  |
|  |

|  |  |  |
| --- | --- | --- |
| Medical Professional Signature |  | Date |
| Medical Professional Name (printed) |  | Medical ID # |
| Address |  | Phone |
| City/State/Zip |  |  |