OFFICE USE ONLY

Case Number: _____

MEDICAL INQUIRY FORM
FOR EMPLOYEE ADA ACCOMMODATION REQUEST
(To be completed by Health Care Provider)

RETURN COMPLETED FORM TO: Tara L. Berrien, AVP of Diversity, EEO, and Title IX, tara.berrien@morgan.edu; Tyler Hall, Room 503, 1700 E. Cold Spring Lane, Baltimore, MD 21251; Phone: 443-885-3559 (Confidential)

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Name_____ **Job Title**_____

A. QUESTIONS TO HELP DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY

A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. The following questions may help determine whether an employee has a disability:

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

What is the impairment/diagnosis? _____

Is the impairment long-term or permanent? ☐ Yes ☐ No

If *not* permanent, how long will the impairment likely last? _____

Does the impairment affect a major life activity? ☐ Yes ☐ No

If *yes*, what major life activity(ies) is/are affected?

☐Caring for Self	☐Walking	☐Hearing	☐Lifting	☐Standing
☐Interacting with Others	☐Seeing	☐Sleeping	☐Eating	☐Reading
☐Performing Manual Tasks	☐Reaching	☐Speaking	☐Concentrating	☐Sitting
☐Breathing	☐Thinking	☐Learning	☐Working	☐Bending

☐Other: _____

Is the employee substantially limited in one or more of these major life activities? ☐Yes ☐ No

B. QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Which of the major life activities selected are interfering with the employee's ability to perform the job functions?

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

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

C. QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Please state any suggestions regarding possible accommodations to improve the employee's ability to perform his/her job.

How would your suggestions improve the employee's ability to perform the job functions?

D. ADDITIONAL COMMENTS

Physician's Name (*Please Print)* _____

Physician's Signature: _____ **Date**_____

Phone: _____ **Fax:** _____