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REQUESTING REASONABLE ACCOMMODATION: MEDICAL INQUIRY FORM

SECTION I. EMPLOYEE INFORMATION: TO BE COMPLETED BY EMPLOYEE	
Employee Name:	Email:
Employee's Supervisor:	Telephone:

SECTION II. MEDICAL INFORMATION: TO BE COMPLETED BY PHYSICIAN

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 and whether the requested accommodation is needed because of the disability:

HISTORY

Does the employee have a physical, psychological, or other impairment which causes limitation(s)?

If yes, what is the nature of the limitation(s)?

Diagnosis:

Subjective symptoms:

When did the symptoms first appear (Date and Year)?

Date employee ceased work because of disability?

Has employee ever had same or similar condition?

Does the impairment substantially limit a major life activity as compared to most people in the general population? If so, please state.

REQUESTING ACCOMMODATION

What limitation(s) is interfering with job performance or access to a benefit of employment? (list medical limitation(s) here)

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What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)? (list job function(s) or benefit(s) here)		
Would job modification enable patient to work with impairment?	Yes ☐	No ☐

ACCOMODATION OPTIONS		
Do you have any suggestions regarding proposed accommodations to improve job performance?	Yes ☐	No ☐
If so, please state.		
Is the proposed accommodation temporary or permanent?	Temporary ☐	Permanent ☐
Is temporary, for how long?		
How would your suggestions improve the employee's job performance?		

SECTION III. COMMENTS NOT OTHERWISE ADDRESSED

SECTION IV.

Healthcare Provider's Name: ____ Date: ____________________

Phone #: ___________________________ Street address: ____

City: _______________________________ State: __________________ Zip code: _______________________________

Physician's Signature: ____

Please return form to Louisiana State University, 110 Thomas Boyd Hall, Office of Human Resource Management Attention: Lindsay Madatic and Anissa Chenevert. Fax: 225-578-6571