MEDICAL INQUIRY FORM

Responsive to ADA Accommodation Request

Agency Name: _____

Return completed form to Agency ADA Coordinator:

Name: _____ Email: _____

Phone #: _____ Fax #: _____

CONFIDENTIALITY STATEMENT: A request for accommodation, including medical and other relevant information, is privileged and may only be released as appropriate to individuals with a business need to know. (Rev. 4/2025)

For Completion by Employee

Employee Name: _____

Authorization for Release of Medical Information

I authorize my Healthcare Provider to release medical information that is specifically related to and necessary for my employer to determine whether I have a disability for which an accommodation(s) may be needed. I authorize my Healthcare Provider to speak directly to my Agency ADA Coordinator in regards to my medical condition and its effects upon my ability to perform the essential functions of my job. I understand that I may refuse to sign this Authorization. However, I understand that my failure to permit these disclosures may impact my employer's ability to fully address my request for accommodation.

Employee's Signature: _____ Date: _____

For Completion by Healthcare Provider

SECTION 1: Questions to determine whether employee has a disability

For reasonable accommodation under the Americans with Disabilities Act (ADA), an employee has a disability if he/she has an impairment that substantially limits one or more major life activities or has a record of such an impairment. The following information may help to determine whether an employee has a disability:

Does the employee have a physical or mental impairment?

☐ Yes *(proceed to section A. below)* ☐ No *(discontinue completion of form)*

A. What is the impairment or nature of the impairment.

B. Does the impairment substantially limit a major life activity as compared to the general population?

☐ Yes *(proceed to section C. below)* ☐ No *(discontinue completion of form)*

C. What major life activity(s) and/or major bodily function(s) is limited?

Major Life Activities:

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

Major Bodily Functions:

- ☐ Bladder
- ☐ Bowel
- ☐ Brain
- ☐ Cardiovascular
- ☐ Circulatory
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinary
- ☐ Hemic
- ☐ Immune
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Normal Cell Growth
- ☐ Operation of an Organ
- ☐ Reproductive
- ☐ Respiratory
- ☐ Special Sense Organs & Skin

D. Describe any functional limitations caused by the impairment.

SECTION 2: Questions to 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 information may help determine whether the requested accommodation is needed because of the disability:

A. What job duties is the employee unable to perform or having difficulty performing?

B. How does the employee's functional limitations interfere with his/her ability to perform required job duties?

Healthcare Provider's Signature: _____ Date: _____

Healthcare Provider's Name *(Printed)*: _____

Clinic Name: _____ Practice Specialty: _____

Address: _____

Phone Number: _____ Fax Number: _____