MEDICAL INQUIRY FORM IN RESPONSE TO REQUEST FOR ACCOMMODATION BASED ON A DISABILITY

Drafted 8/25/21

Updated 1/17/25

Employee Information

Date: _____ Employee Name: _____ TUID: _____

Job Title: _____ Department: _____

To Be Completed by Physician or Appropriate Medical Professional

The remaining sections of this form are to be completed and signed only by the employee's Health Care Provider to confirm the need for a reasonable workplace accommodation due to a qualifying disability. This information will be reviewed to identify appropriate reasonable accommodations that do not cause an undue hardship on operations. Content of this request is confidential and will not be shared by any staff member of the Office for Campus Accessibility except to consider the implementation of the disability accommodation.

Information to Determine Existence of Disability

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.

Does the individual have a record of a physical or mental impairment? ☐ Yes ☐ No

If yes, please describe the physical or mental impairment (including the nature, symptoms, treatment plan, and severity of the impairment):

What is the duration of the physical or mental impairment? ☐ Temporary ☐ Indefinite (longer than 6 mo.) ☐ Unknown

If temporary, please provide the estimated end date of restrictions: _____

Answer the following questions based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity? *Note: Does not need to significantly or severely restrict to meet this standard.*			☐ Yes ☐ No	
If yes, what major life activity(s) is/are affected?				
☐ Caring for self ☐ Walking ☐ Hearing ☐ Lifting	☐ Interacting with others ☐ Standing ☐ Seeing ☐ Sleeping	☐ Performing Manual Tasks ☐ Reaching ☐ Speaking ☐ Concentrating	☐ Breathing ☐ Thinking ☐ Learning ☐ Reproduction	☐ Working ☐ Toileting ☐ Sitting ☐ Mental Illness
Others:				

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Does the impairment substantially limit the operation of a major bodily function? *Note: Does not need to significantly or severely restrict to meet this standard.*	☐ Yes ☐ No			
If yes, what bodily function(s) is/are affected?				
☐ Immune ☐ Hemic ☐ Circulatory ☐ Normal Cell Growth	☐ Respiratory ☐ Endocrine ☐ Digestive ☐ Lymphatic	☐ Reproductive ☐ Bowel ☐ Neurological ☐ Musculoskeletal	☐ Bladder ☐ Sensory ☐ Genitourinary ☐ Organs and Skin	☐ Cardiovascular ☐ Brain ☐ Speech Organs ☐ Immunological
Others:				

Questions To Help 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 questions may help determine whether the requested accommodation is needed because of the disability.

1. **What functional limitation(s) resulting from the employee's impairment(s) interfere with the employee's job performance?**

2. **What job function(s) is/are the employee having trouble performing because of such functional limitation(s)?**

3. **How does the employee's functional limitations interfere with his/her/their ability to perform the job functions?**

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Safe Harbor Provision Under GINA

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.

Medical Provider Information

Medical Provider Name (please print): _____

Name of Medical Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email address: _____

Medical Provider's Signature: _____ Date: _____

Please Return Form To:

Office for Campus Accessibility
7001 Freret St., Building 60, Ste. B25
New Orleans, Louisiana 70118
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Fax: (504) 862-8435
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