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 the form via Email to: Employee Relations at employeerelations@philasd.org ***or*** *First Class Mail to Office of Talent, 440 North Broad Street, Suite 202, Philadelphia, PA 19130* ***or*** *by fax at 215.400.4601*

Employee Name:_____ Position:_____
(Print Name)

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?

   _____
5. Does the impairment limit the employee's ability to engage in any life activities? Yes❒ No❒
6. 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	_____

7. 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.

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

_____

_____

_____

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

_____

_____

_____

10. 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