[1]MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

Print Employee Name: _____ **Banner ID: 000**_____

Your patient has requested an accommodation related to their position with our organization, which may qualify under the Americans with Disabilities Act (ADA) as a reasonable accommodation. **Please complete this form and email it to your Human Resources Consultant.**

A. Questions to help determine whether an employee has a disability.

Under ADA, an employee

Do you have any suggestions, other than time away from work, regarding possible accommodations to enable performance of job functions? Yes No

If yes, what are they?

Yes No

If so, please list the date your patient could return to work: ____________________(mm/dd/yyyy)

How would your suggestions improv ?

Will your patient have work restrictions upon returning to work? Yes No

If yes, please describe the restrictions and indicate how long each restriction will continue:

D. Complete Part D if patient is requesting leave as an accommodation:

Frequency of Absence: Wil.61503.8 011.04To1rBT/F1 11.04Tf1 0 0 1 61503 ct(t)-4(r)-3(aiEMC q3680.8 5.93 (u)ien)3(cy)-4(o)1

Part D2

Probably end date for leave:

____/_____/_____(mm/dd/yyyy)

work but will not need a reduced schedule.

Sun	_____hours off	Not scheduled to work
Mon	_____hours off	Not scheduled to work
Tu	_____hours off	Not scheduled to work
Wed	_____hours off	Not scheduled to work