



EEO Services Unit

OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AFFAIRS



**REASONABLE ACCOMMODATION REQUEST MEDICAL INQUIRY FORM**

<b>Employee Name:</b>	<b>Date:</b>
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**A. Does the employee have a disability?**

For reasonable accommodation(s) under the Americans with Disabilities Act, as amended, an employee has a disability if he/she has an impairment that substantially limits one (1) or more major life activities and/or major bodily functions or a record of such impairment. The following questions may help determine whether an employee has a disability.

1. Does the employee have a physical or mental impairment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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a. If yes, what is the impairment?

2. Diagnosis?

3. Prognosis?



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## 4. Medications related to diagnosis?

Answer the following question based on what limitations the employee has when his/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, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and/or physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

5. Does the impairment substantially limit a major life activity and/or major bodily function as compared to most people in the general population?

*Note: Does not need to significantly or severely restrict to meet this standard. It may be useful in certain cases to consider the condition under which the individual performs the major life activity and/or major bodily function; the manner in which the individual performs the major life activity and/or major bodily function; and/or the duration of time it takes the individual to perform the major life activity and/or major bodily function, or for which the individual can perform the major life activity.*

Yes

No

a. If yes, what major life activity(s) is/are affected?

- |  |  |                                   |                                   |  |
|--|--|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Bending         | <input type="checkbox"/> Hearing                 | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other (describe):<br>_____<br>_____<br>_____<br>_____ |
| <input type="checkbox"/> Breathing       | <input type="checkbox"/> Interacting with Others | <input type="checkbox"/> Reading  | <input type="checkbox"/> Standing |  |
| <input type="checkbox"/> Caring For Self | <input type="checkbox"/> Learning                | <input type="checkbox"/> Seeing   | <input type="checkbox"/> Thinking |  |
| <input type="checkbox"/> Concentrating   | <input type="checkbox"/> Lifting                 | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Walking  |  |
| <input type="checkbox"/> Eating          | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working  |  |



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b. If yes, what major bodily function(s) is/are affected?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Digestive     | <input type="checkbox"/> Lymphatic             | <input type="checkbox"/> Reproductive                |
| <input type="checkbox"/> Bowel          | <input type="checkbox"/> Endocrine     | <input type="checkbox"/> Musculoskeletal       | <input type="checkbox"/> Respiratory                 |
| <input type="checkbox"/> Brain          | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological          | <input type="checkbox"/> Special Sense Organs & Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hemic         | <input type="checkbox"/> Normal Cell Growth    | <input type="checkbox"/> Other: (describe)           |
| <input type="checkbox"/> Circulatory    | <input type="checkbox"/> Immune        | <input type="checkbox"/> Operation of an Organ | _____  |
|   |  |  | _____  |

### B. Is an accommodation 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 limitation(s) is/are interfering with job performance or accessing a benefit of employment?

2. What job function(s) or benefits of employment is/are the employee having trouble performing or accessing because of the limitation(s)?

3. How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?



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4. The following duty limitations/restrictions apply:	
Expected end date, if applicable: _____	
Impacted Activity, if applicable	Additional Details
<input type="checkbox"/> No lifting / <input type="checkbox"/> Carrying ( <i>please check</i> ) <input type="checkbox"/> No pushing <input type="checkbox"/> No pulling <input type="checkbox"/> No climbing <input type="checkbox"/> No running <input type="checkbox"/> No walking <input type="checkbox"/> No jumping <input type="checkbox"/> No work above shoulder height <input type="checkbox"/> No kneeling, bending, twisting, squatting <input type="checkbox"/> No operating a motor vehicle <input type="checkbox"/> No prolonged standing, ( <i>please define</i> ) _____ <input type="checkbox"/> No prolonged sitting, ( <i>please define</i> ) _____ <input type="checkbox"/> No grasping <input type="checkbox"/> No assignments in altitudes above 7,000 feet and/or air travel <input type="checkbox"/> No participation in defensive tactics	Weight Restriction at or above: _____ pounds
<input type="checkbox"/> No participation in raids, arrests, undercover surveillance, or reactive squad duty: _____	
<input type="checkbox"/> No Firearms for training & qualification due to: 1. <input type="checkbox"/> Illness/Injury or 2. <input type="checkbox"/> Breastfeeding	
<input type="checkbox"/> Other Limitations/Restrictions: _____	
<input type="checkbox"/> Comments:	
5. Maximum Medical Improvement Achieved? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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### C. Recommended

If an employee has a disability and needs an accommodation(s) because of the disability, the employer must provide a reasonable and effective accommodation(s) for both the employee and the Agency, unless the accommodation(s) poses an undue hardship. The following questions may help determine reasonable and effective accommodations:

1. Do you have any suggestions regarding possible accommodation(s) to improve job performance?

Yes  No If yes, what are they?

2. How would your suggestions improve the employee's job performance?

### D. Other comments or additional information

**Medical Professional's Signature:**

**Medical Professional's Name Print:**

**Date:**

**Telephone:**

**Specialty:**

Please be advised the Genetic Information Non-discrimination Act of 2008 (GINA) prohibits employers and other entities covered by Title II of GINA 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, the Office of Equal Employment Opportunity Affairs is requesting 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 genetic tests or those of his/her family member(s), the fact an individual or his/her family member(s) sought or received genetic services, and genetic information of a fetus carried by an individual or an individual family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.