CALIFORNIA STATE UNIVERSITY SAN BERNARDINO Human Resources

# Medical Provider Inquiry Form in Response to an Accommodation Request

Sierra Hall,Room 102, Phone (909) 537-3720, Email Alisha.Carnahan@csusb.edu

Employee Name:_____Phone:_____Email: _____

## A. Questions to Help Determine the Employee's Specific Limitations

In order to qualify for a reasonable accommodation, an employee must have either a disability which results in an impairment that limits one or more major life activities, or a record of such impairment. Your answers to the following questions may help determine whether the employee has such an impairment or record thereof. [1]

**1.** Is the impairment or medical condition long-term or permanent? Yes ☐ No ☐

**2.** If **NOT** permanent, how long will the impairment or medical condition likely last? _____

Please answer the following questions based on what limitations the employee has when his or her condition is **in an active state and no mitigating measures are 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.

**3.** Does the impairment or medical condition limit a major life activity? Yes ☐ No ☐

**4.** If yes, what is the functional limitation(s)? Please do NOT provide a diagnosis.
*Example: walking is limited to .5 miles at a time, limit standing to no more than 30 minutes at a time, no lifting over 10lbs. for two weeks*

*CONTINUED ON NEXT PAGE.*

[1] 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.

| Major Life Activity | Duration | Severity |
|---|---|---|
| *Example: standing* | *Two weeks* | *Limit to 30 min at a time* |
| Bending | | |
| Bladder/bowel | | |
| Breathing | | |
| Caring for oneself | | |
| Circulatory | | |
| Communicating | | |
| Concentrating | | |
| Digestive | | |
| Hearing | | |
| Interacting with others | | |
| Learning | | |
| Lifting ( lbs.) | | |
| Performing manual tasks | | |
| Reaching | | |
| Reading | | |
| Seeing | | |
| Sitting | | |
| Sleeping | | |
| Speaking | | |
| Standing | | |
| Thinking | | |
| Walking | | |
| Working | | |
| Other (Specify): | | |

*CONTINUED ON NEXT PAGE.*

## B. Questions to Help Determine Effective Accommodation Options

Your answers to the following questions help determine effective accommodations:

- Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are your suggestions?

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

## C. Additional Questions

1. Does the employee have a disability and/or medical condition that makes them at an "increased risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19?

☐ Employee DOES NOT HAVE a disability and/or medical condition that makes them at an "increased risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19. (Please skip to "D. Other comments" and sign, date, and return the form

☐ Employee DOES HAVE a disability and/or medical condition that medically requires LIMITING his/her exposure to coronavirus and/or COVID-19, but not "increased risk" as outlined by the Centers for Disease Control (CDC) as it pertains to COVID-19 (Please continue completing the form)

- **PLEASE IDENTIFY WORKPLACE RISKS THAT NEED TO BE ACCOMMODATED OR MITIGATED TO ENSURE A SAFE WORK ENVIRONMENT FOR YOUR PATIENT. WHAT IS IN THE PHYSICAL WORKPLACE THAT IS A MEDICAL RISK FOR YOUR PATIENT:**

- **PLEASE IDENTIFY WORKPLACE FACTORS THAT MUST BE PRESENT IN A WORKPLACE TO ENSURE YOUR PATIENT IS SAFE. WHAT ACCOMMODATIONS NEED TO BE IMPLEMENTED FOR YOUR PATIENT IN ANY WORK ENVIRONMENT THEY WORK IN?**

*CONTINUED ON NEXT PAGE.*

## D. Other Comments

## E. Medical Provider Information

Medical Provider Name: _____

Name of Medical Practice: _____

Address:_____City:_____State:____Zip: _____

Phone:_____Alt Phone:_____Email:_____

**Medical Provider's Signature:**_____**Date:**_____

**Once completed, this form may be either returned to the employee or mailed to the address below. The employee may choose to either return the form to the ADA Coordinator, in person (SH 102), by email to Alisha.Carnahan@csusb.edu, or mail it to:**

**Human Resources**
**Attn: Alisha Carnahan**
**California State University, San Bernardino**
**5500 University Parkway**
**San Bernardino, CA 92407**