To the Health Care Provider: Please complete this form in full. This questionnaire is part of an interactive process that is necessary in order to determine if your patient (our employee) has a disability recognized under the Americans With Disabilities Act, and, if so, what, if any, reasonable accommodation(s) are necessary and can be made that would enable your patient to perform the essential functions of his or her job. Please review the job description provided prior to completing this form.

NOTE: When answering the questions in Section A below, please access the patient's condition without regard to the ameliorative effects of mitigating measures, such as medication, medical supplies or equipment, prosthetics, assistive technology, reasonable accommodations or auxiliary aids, or behavioral or adaptive neurological modifications.

Employee/Patient Name: ________________________________________________________________

SECTION A: PATIENT INFORMATION

1. Does this patient have a physical or mental impairment? ________ Yes     ________ No
   If so, please identify/state the impairment. ________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

2. When did the patient first experience this medical condition(s) (approximate date/year)? __________
   What is the expected duration of the patient's medical condition(s)? Is the condition permanent or temporary?
   If temporary, what is the expected duration of the condition? ________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

3. In your medical opinion, does the patient’s medical condition limit his or her ability to perform any major life activities? (Major life activities include, but are not limited to caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, sitting, reaching, and the operation of major bodily functions, such as functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions).
   ________  Yes     ________ No
   If "Yes," please list all major life activities that are limited to his/her medical condition. If "No," you need not answer any further; just provide the Certification Information at the end of page 2. ________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
Employee's Affected Major Life Activities:

- Seeing
- Hearing
- Speaking, Communicating
- Eating
- Sleeping
- Working**

- Walking, Standing, Lifting, Bending
- Breathing
- Performing Manual Tasks
- Learning, Reading, Concentrating, Thinking
- Caring for Self
- None

Employee's Affected Major Bodily Functions:

- Immune System
- Endocrine
- Respiratory
- None

- Digestive, Bowel, Bladder
- Neurological, Brain
- Circulatory

4. What type of workplace activities or job functions is the patient unable or limited in his/her ability to perform, if any?

Please describe how and the extent to which the patient's physical or mental impairment substantially or significantly limits his/her ability to perform workplace activities or job functions. If not limitations or restrictions, state so.

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<th>Restrictions or Limitations</th>
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5. Please describe the expected duration of each limitation listed in the answers above (as distinguished from the duration of the condition itself). Please provide specifics, to the extent possible (e.g., number of days, weeks or months).

___________________________________________________________________________________________________
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6. Do you consider any of the patient’s limitations to be temporary and non-chronic? If so, which ones?
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

7. In your medical opinion, for each major life activity identified, is the patient materially (less than significantly but more than moderately) restricted in his/her ability to perform that activity, as compared to the ability of an average person in the general population? If so, please explain.
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

SECTION B: ACCOMMODATIONS

1. Do you know of any job modification(s) or other accommodation(s) that would enable the patient to perform the job functions that you identified?

____________ Yes __________ No

If "Yes", please describe in detail the suggested modification(s) or other accommodation(s).
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

2. Does the patient need a leave of absence for the condition? _______ Yes _______ No

If "Yes", for how long will the patient need to be off of work (even if it's only an estimate)?______________________
_____________________________________________________________________________________________
4. Is the patient taking any medication(s) or undergoing any treatments that affect the patient’s ability to perform one or more functions of his/her job?  _______Yes  _______No

If “Yes”, please explain such effects and list any and all job restrictions you recommend.

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

CERTIFICATION OF PHYSICIAN/HEALTH CARE PROVIDER

I hereby certify that all of the foregoing information is true and correct.

Signature of Provider:__________________________________________________________
Printed Name of Provider:_____________________________________________________
Area of Practice/Specialty:_____________________________________________________
Date Signed:________________________________________
Telephone Number of Provider: _________________________ Fax Number:_______________________