ADA – Form – Physician Questionnaire

Your patient is an employee of Hazelwood School District and has requested an accommodation. In order to expedite the processing of your patient's request for an accommodation, please be as complete and specific as possible. **Once completed, please return this document to your patient.** The patient will return the document to the Human Resources Department. **PLEASE PRINT OR TYPE YOUR RESPONSES.**

Name of Patient:
Name of Caregiver:
Title:
Address:
Brief description of practice:

SECTION ONE: PHYSICAL OR MENTAL IMPAIRMENT

1. Does your patient have any physical or mental impairment(s)? ___ NO ___ YES

   If yes, please state the impairment(s):

   _____

   _____

   _____

2. If your patient has a history of the impairment indicated in question #1, please indicate the date the condition commenced and describe in detail any previous medical restrictions associated with the impairment and the degree to which your patient was limited:

   _____

   _____

   _____

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.

Hazelwood School District

3. If a life activity is limited by the physical or mental impairment listed in question #1, please identify which life activity is limited. (Please check all that apply)

☐ Caring for Oneself	☐ Walking	☐ Seeing	☐ Hearing	☐ Eating
☐ Performing Manual Tasks		☐ Speaking	☐ Breathing	☐ Learning
☐ Working	☐ Concentrating	☐ Standing	☐ Sitting	☐ Bending
☐ Toileting	☐ Lifting	☐ Interacting with Others		☐ Hearing
☐ Sleeping	☐ Reaching	☐ Reading	☐ Thinking	☐ Other

(Please specify)

_____

_____

_____

4. Please specify <u>how</u> and to <u>what degree</u> your patient is limited in each of the life activities identified in question #3. For example: If lifting was identified as a limited life activity, how many pounds can your patient lift frequently/occasionally? If working was identified, please specify the class of jobs or broad range of jobs that your patient is unable/able to perform. If performing manual tasks was identified, please specify the tasks that are important to most people's daily lives that your patient is unable/able to perform.

<u>Life Activity</u>	<u>To What Degree Restricted</u>	<u>Able To Perform</u>

If your patient's impairment is episodic in nature, how often and for what period of time do symptoms occur?

_____

_____

_____

5. How long will your patient be limited in performing the life activity or activities as described above?

_____

_____

_____

If unknown, will the leave likely be: _____ a month _____ 3 months _____ 6 months _____ 1 year or more

SECTION TWO: ACCOMMODATION

6. Please review the patient's job requirements in the attached job description. Do the limitations you previously identified restrict your patient's ability to perform the job or comply with the requirements of the position? ____NO ____YES If yes, please identify the functions of your patient's job he or she is able to perform and those functions he or she is unable to perform.

Able Unable

_____

_____

_____

_____

7. Does the employee require a leave of absence? _____Yes _____No

Would your patient's leave be:
Continuous _____
Intermittent _____

If continuous, would your patient's leave be:

Indefinite _____NO _____YES

If not indefinite, please specify **time period** and **return to work date**:

_____

If intermittent, please specify the number of days per month or week that your patient would require a leave, as well as the period of time the intermittent leave is needed for:

_____

8. In your opinion, if your patient cannot perform his or her current job with or without reasonable accommodations, would your patient be able to work in another position? ___NO ___YES

   If yes, please specify what other position or work the patient could do:

   _____

   _____

   _____

SECTION THREE: THREAT TO SELF OR OTHERS

9. Would performing all of the functions of the Employee's job, either with or without an accommodation, result in a direct threat (significant risk of substantial harm) to the safety or health of the employee or other persons? ☐ Yes ☐ No

10. Please describe any direct threat to health or safety identified in Question #9.

    _____

    _____

    _____

11. Would an accommodation eliminate the direct threat to health or safety, or reduce it to below the level of a direct threat? ☐ Yes ☐ No ☐Not Applicable

    If yes, what accommodation, if any, would eliminate any direct threat, or reduce it below the level of a direct threat?

    _____

    _____

    _____

The individual named above is my patient. The information provided here is based upon my knowledge of the patient and the patient's physical or mental impairment.

_____ _____

Signature of Caregiver Date

_____

Phone

_____

Fax #

Please send forms to:

Benefits@hazelwoodschools.org

HAZELWOOD SCHOOL DISTRICT

HUMAN RESOURCES DEPARTMENT

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