**Health Care Provider Statement**

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| 1. **Questions to help determine whether an employee has a disability.** | | | | | | | |
| Does the employee have a physical or mental impairment? | | | | | Yes ⁯ | No ⁯ | |
| If yes, what is the impairment: | | | | | | | |
| Is the impairment long-term or permanent? | | | | | Yes ⁯ | No ⁯ | |
| If not permanent, how long will the impairment likely last? | | | | | | | |
| Answer the following questions based on what limitations the employee has when his or 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, and learned behavioral or adaptive neurological modifications. Mitigating measures do not  include ordinary eyeglasses or contact lenses. | | | | | | | |
| Does the impairment substantially limit a major life activity? | | | | | Yes ⁯ | No ⁯ | |
| If yes, what major life activity(s) is/are affected: | | | | | | | |
| ⁯ Caring For Self  ⁯ Interacting With Others  ⁯ Performing Manual Tasks  ⁯ Breathing  ⁯ Working | ⁯ Walking  ⁯ Standing  ⁯ Reaching  ⁯ Thinking  ⁯ Toileting | | ⁯ Hearing  ⁯ Seeing  ⁯ Speaking  ⁯ Learning  ⁯ Sitting | | ⁯ Lifting  ⁯ Sleeping  ⁯ Concentrating  ⁯ Reproduction | ⁯ Other  (describe) | |
| Does the impairment substantially limit the operation of a major bodily function? | | | | | Yes ⁯ | No ⁯ | |
| If yes, what bodily function is affected? | | | | | | | |
| ⁯ Immune  ⁯ Normal Cell Growth  ⁯ Digestive  ⁯ Bowel  ⁯ Bladder  ⁯ Genitourinary | | ⁯ Hemic  ⁯ Special Sense Organ and Skin  ⁯ Lymphatic  ⁯ Neurological  ⁯ Brain  ⁯ Respiratory | | ⁯ Circulatory  ⁯ Endocrine  ⁯ Reproductive  ⁯ Musculoskeletal  ⁯ Special Sense  ⁯ Cardiovascular | | | ⁯ Other  (describe) |
| 1. **Questions to help determine whether an accommodation is needed.** | | | | | | | |
| Please review the attached job description. Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? | | | | | Yes ⁯ | No ⁯ | |
| If yes, continue to the next question. If no, how long will the employee be unable to perform these job duties? | | | | | | | |
| \_\_\_\_\_\_\_# of weeks \_\_\_\_\_\_\_ # of months \_\_\_\_\_\_\_ permanently | | | | | | | |
| What limitation(s) is/are interfering with job performance? | | | | | | | |
| What job function(s) is the employee having trouble performing because of the limitation(s)? | | | | | | | |
| How does the employee’s limitation(s) interfere with his/her ability to perform the job function(s)? | | | | | | | |
|  | | | | | | | |
| 1. **Questions to help determine effective accommodations to improve job performance?** | | | | | | | |
| If so, what are they? | | | | | | | |
| How would your suggestions improve the employee’s job performance? | | | | | | | |

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| 1. **Comments.** |

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Health Care Provider’s Signature

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Printed Name

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Date

Address:

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Phone:

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Please note that the Genetic Information Nondiscrimination Act of 2008 (GINA) (29CFR 165.8(b)(l)(i)(B) 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, please don 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 family member’s genetic test, the fact that an individual or 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 embryo lawfully held by an individual or family member receiving reproductive services. Please do not send office visit notes as they may contain medical information not relevant to the request for accommodation.