DEPARTMENT OF SOCIAL SERVICES
Division of Affirmative Action
Americans with Disabilities Act (ADA), as Amended 2008

Health Care Provider's Questionnaire

(To be completed by treating health care provider)

Employee Name: _____

Job Title: _____

Physician's Name: _____

Type of Practice: _____

Address: _____

I, _____understand that you may have questions about my request and may need to contact my health care provider. I hereby give you permission to do so.

Employee Signature/Date XX_____

INSTRUCTIONS TO HEALTH CARE PROVIDER:

Your patient/our employee, _____has made a Request for Reasonable Accommodation under the Americans with Disabilities Act and Americans with Disabilities Act as Amended, 2008. In order to process this request, our division needs your assistance with responding to the following questions. Please feel free to attach additional pages if necessary.

1. Does _____ have a physical or mental impairment?

   ☐ Yes ☐ No

   Since what date has the employee had this condition or impairment? _____

2. When did you last examine/see our employee related to the condition? _____

3. Is the Employee's condition permanent or temporary? Permanent ☐ Temporary ☐

4. What is the nature of the employee's condition or impairment for which the employee is being treated and requesting job modification/accommodations? Please include in your description how the condition or impairment manifests itself.

   _____

   _____

   _____

   _____

5. Is the Employee substantially limited in any major life activities as a result of his/her health condition?

   ☐ Yes ☐ No

6. If so, please identify the major life activities or major bodily functions.

7. What functions or activities does the employee have difficulty performing as a result of this condition(s) and why? For example, limitations such as the inability to reach, stand, bend, grip, concentrate, speak, etc. With regard to each function or activity listed above, describe in detail how and to what extent each is limited, along with the duration,(the time period that you anticipate each to be limited) severity and frequency.

8. Is the Employee unable to perform any of the essential functions of his/her job as listed in the attached job description or limited in his/her ability to do so? If so, please identify each limitation or inability to perform and the expected duration.

9. To your knowledge, has the employee been treating with any other physician/provider(s) for this or any other condition that has contributed to his/her inability to work? If yes, who?

_____

_____

_____

_____

_____

10. Based upon your knowledge of the Employee's condition, are there any accommodations that the agency can provide that you believe would permit the employee to perform the essential functions of his/her job?

_____

_____

_____

_____

_____

Physician Declaration:

I understand that I am providing information to assist the Department of Social Services in determining whether it can provide a reasonable accommodation for my patient . I certify that the information I am providing is true and correct and accurately reflects my medical assessment and opinion.

_____ _____

Physician Name (please print clearly) Physician Signature

Date: _____ License# _____

Physician's Office: Please fax the completed form to Nisa B. Davey, EEO Specialist 1 at 860-424-4948

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.

To be completed by Division of Affirmative Action:

Initial Rec'd Date: _____	**Received by:** _____