



MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

NAME OF PATIENT/EMPLOYEE: _____

DATE: _____

**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 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

A. Questions to help determine whether an employee has a disability.				
For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such impairment. The following questions may 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 (not the diagnosis)?				
What are the restrictions of the impairment? (e.g. limit standing up to 1 hour or less a day)				
Is the impairment long-term or permanent?	Yes	No		
If not permanent, how long will the impairment likely last?				
Does the impairment substantially limit a major life activity? <i>Note: Does not need to significantly or severely restrict to meet this standard</i>	Yes	No		
If yes, what major life activity(s) is/are affected?				
Caring For Self	Walking	Hearing	Lifting	Others: (describe below)
Interacting with Others	Standing	Seeing	Sleeping	_____
Performing Manual Tasks	Reaching	Speaking	Concentrating	_____
Breathing	Thinking	Learning	Reproduction	_____
Working	Toileting	Sitting	Mental Illness	_____
Does the impairment substantially limit the operation of a major bodily function? <i>Note: Does not need to significantly or severely restrict to meet this standard.</i>	Yes	No		
If yes, what bodily function is affected?				
Immune	Hemic	Circulatory	Others: (describe below)	
Normal Cell Growth	Respiratory	Endocrine	_____	
Digestive	Lymphatic	Reproductive	_____	
Bowel	Neurological	Musculoskeletal	_____	
Bladder	Sensory	Genitourinary	_____	
Organs and Skin	Cardiovascular	Brain	_____	
Speech Organs	Immunological		_____	

RESPONSE TO A DISABILITY ACCOMMODATION REQUEST FORM (CONTD.)

B. Questions to help determine effective accommodation options.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of a disability. The following questions may help determine whether the requested accommodation is needed because of a disability.

What are the specific restrictions to these limitations and the durations? (see chart below) This information will ensure how best to provide a reasonable accommodation that aligns with our University policies and procedures.

Major Life Activity Bodily/Function	Specific Functional Limitation or Restriction (i.e., specific items or issues to address based on the covered disability)	Duration based on the functional Limitation (i.e. time restrictions)
Example 1: Lifting	1. Avoid lifting more than 10 pounds	1. A day
Example 2: Breathing	2. Avoid heavily scented items or perfumes	2. At all times OR provide a portable fan
Example 3: Standing	3. Avoid standing on hard surfaces	3. Not to exceed 2 hours a day

Please clarify how the above limitation(s) will enable this employee to perform the essential function(s) of the job.

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)?



RESPONSE TO A DISABILITY ACCOMMODATION REQUEST FOIRM (CONTD.)

C. Questions to help determine effective accommodation options.

If an employee has a disability and needs an accommodation because of the disability, the employer must provide reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations.

Do you have any suggestions regarding possible accommodations to improve job performance?

If so, what are they?

How would your suggestions improve the employee's ability to perform the essential function(s) of the job?

Other comments:

Medical Provider Information:

Medical Provider Name

(Please Print): _____

Name of Medical Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ E-Mail: _____

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

Note: Once completed, this form may be either returned to the employee or mailed to the address below. The employee may choose either.

California State University, Fullerton

Human Resources, Diversity and Inclusion - Total Wellness

Attn: Griselda M. Marquez, Manager, Workers' Compensation, Leaves and Disability Accommodations

P.O. Box 6806 Fullerton, CA 92834-6806

For Office Use Only: **Date Received:** _____ **Initial:** _____