MEDICAL INQUIRY FORM
RESPONSIVE TO ACCOMMODATION REQUEST

FOR COMPLETION BY EMPLOYEE

CONFIDENTIALITY STATEMENT:
A request for accommodation, including medical and other relevant information, is privileged and may only be released as appropriate to individuals with a business need to know.

Employee's Name: _____

Authorization for Release of Medical Information

I authorize my Healthcare Provider to release medical information that is specifically related to and necessary for my employer to determine whether I have a disability for which an accommodation(s) may be needed. I authorize my Healthcare Provider to speak directly to my Agency ADA Coordinator in regards to my medical condition and its effects upon my ability to perform the essential functions of my job. I understand that I may refuse to sign this Authorization. However, I understand that my failure to permit these disclosures may impact my employer's ability to fully address my request for accommodation.

Employee's Signature: _____ Date: _____

FOR COMPLETION BY HEALTHCARE PROVIDER

SECTION 1: Questions to determine whether employee has a disability

For reasonable accommodation under the Americans with Disabilities Act (ADA), an employee has a disability if he/she has an impairment that substantially limits one or more major life activities or has a record of such an impairment. The following information may help to determine whether an employee has a disability:

Does the employee have a physical or mental impairment?

☐ Yes *(proceed to section A. below)* ☐ No *(complete provider information on page 2, sign and return)*

A. What is the impairment or the nature of the impairment? _____
_____
_____
_____
_____

B. Does the impairment substantially limit a major life activity as compared to the general population?
☐ Yes ☐ No

C. What major life activity(s) and/or major bodily function(s) is limited?

Major Life Activities:

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

☐ Other: _____

Major Bodily Functions:

☐ Bladder	☐ Circulatory	☐ Hemic	☐ Neurological	☐ Respiratory
☐ Bowel	☐ Digestive	☐ Immune	☐ Normal Cell Growth	☐ Special Sense Organs & Skin
☐ Brain	☐ Endocrine	☐ Lymphatic	☐ Operation of an Organ	
☐ Cardiovascular	☐ Genitourinary	☐ Musculoskeletal	☐ Reproductive	

☐ Other: _____

D. Describe any functional limitations caused by the impairment:_____
_____
_____
_____
_____
_____

SECTION 2: Questions to help determine whether an accommodation is needed.

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

A. What job duties is the employee unable to perform or having difficulty performing?
_____
_____
_____
_____
_____

B. How does the employee's functional limitation(s) interfere with his/her ability to perform required job duties? _____
_____
_____
_____
_____

C. What is the anticipated period of time the employee's ability to perform required job duties will be limited?_____
_____

Health Care Provider's Signature: _____ **Date:** _____

Health Care Provider's Name (Printed): _____
Practice Specialty: _____
Clinic Name: _____
Address: _____
Telephone #: _____ Fax #: _____

RETURN COMPLETED FORM DIRECTLY TO LAURA TURNER, DOA ADA COORDINATOR
By Fax to: (225) 219-9558; or email to: Laura.Turner3@la.gov