



# Medical Inquiry to Support Reasonable Accommodation Request

**Directions:** To be completed by the Employee/Applicant's health care provider after discussion with employee/applicant.

**Submit to:** AACPS, Human Resources, 2644 Riva Road, Annapolis, MD 21401; fax: 443-458-0140

Employee/Applicant Name		Health Care Provider's Name (please print)	
Job Title		Health Care Provider's Signature	Date
Office/Work Location	Work Phone	Address	Phone

## A. Employee/Applicant Disability

Do you **currently** treat this employee/applicant for the condition for which s/he seeks an accommodation?  Yes  No | If **yes**, for how long have **you** been the treating physician for the condition?

Does the employee/applicant have either a physical or mental impairment?  Yes  No | If **yes**, what is the impairment?

Is the impairment long-term or permanent?  Long-term  Permanent | If **not permanent**, how long is the impairment likely to last?

Which, if any, of the following major life activities is/are affected?

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Caring for self         | <input type="checkbox"/> Reaching | <input type="checkbox"/> Learning               |
| <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Eating   | <input type="checkbox"/> Concentrating          |
| <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> Thinking | <input type="checkbox"/> Lifting                |
| <input type="checkbox"/> Bodily functions        | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Sleeping               |
| <input type="checkbox"/> Breathing               | <input type="checkbox"/> Hearing  | <input type="checkbox"/> Working                |
| <input type="checkbox"/> Toileting               | <input type="checkbox"/> Seeing   | <input type="checkbox"/> Bending                |
| <input type="checkbox"/> Walking                 | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Standing                | <input type="checkbox"/> Reading  |   |

Please describe the **severity of the effect** on the major life activities selected above.

## B. Effect of the Disability on Employment

Which job function(s) is/are the employee/applicant having trouble performing because of limitation(s)?

How does the employee/applicant's limitations **currently** interfere with his/her ability to perform the job function(s)?

*continued on reverse*

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### C. Proposed Accommodations

As the Health Care Provider, do you have any suggestions regarding accommodations that may enable the employee/applicant to perform his/her job satisfactorily? If so, please describe them. If recommending devices, software, and/or equipment, you may make specific suggestions regarding brands and models.

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How would your suggestions improve the employee/applicant's ability to perform the essential functions of his/her job?

### D. Additional Health Care Provider Comments