Human Resources

Americans with Disabilities Act (ADA)

Medical Information Questionnaire

Employee Name: _____	Employee ID #:_____
Department: _____	Job Title: _____

Purpose: The purpose of this form is to assist Weber County in determining whether, or to what extent, a reasonable accommodation is required for an employee to perform the essential functions of his or her job safely and effectively. This form should be completed when an employee has indicated his or her desire to request a reasonable accommodation[1] from Weber County. Upon completion, this form should be returned to Human Resources at the Weber Center, 2380 Washington Blvd. Suite #340 in Ogden, and kept separate from the employee's personnel file.

TO BE COMPLETED BY THE MEDICAL PROVIDER:

What is your diagnosis(es) per the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM-5)?

Prognosis: Are the impairments and/or limitations **permanent, or will there be changes** over time? Please **describe any anticipated changes** and include the basis for your opinions.

If this condition is **episodic or in remission**, please detail the **nature, frequency, severity and duration** of anticipated future episodes. Please list any accommodation(s) that may enable the employee to perform the essential functions of the position during these episodes.

Frequency _____ Times per_____ Week_____ Month_____ Duration_____
Hours or _____ Days per episode_____

Describe the **detrimental effects** of all mitigating measures, (e.g. medication, therapy, assistive devices) that may affect the performance of major life activities.

[1] The statutory definition of disability is a person with a physical or mental impairment that substantially limits one or more of the major life activities of such individual. 42 U.S.C. 12102(2); see also C.F.R. 1630.2(g

Compared to the average person in the general population, please identify each **major life activity**[2] that is **substantially limited** by the diagnosis. Please quantify the limitations, if possible, by indicating how and to what extent each major life activity is limited.

Describe any and all **essential job function(s)**[3] for which the employee may need a **reasonable accommodation(s)**, given your current diagnosis and prognosis.

In your opinion, what **accommodations,** if any, will enable the employee to **perform the essential functions** of his/her current position? (A copy of the job description or list of the essential functions of this position may be attached for your use.)

Please feel free to provide additional comments you believe might be helpful in determining what accommodations are appropriate.

Employee's Name **Signature** **Date**

[2] According to the ADA, **major life activities may include, but are not limited to,** caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communication, working and major bodily functions. **Major bodily functions include, but are not limited to,** functions of the immune system, normal cell growth, digestive, bowel, bladder, etc.

[3] The U.S. Equal Employment commission has indicated that an **employer never has to remove an essential function of the job** as an accommodation. Additionally, **an employee with a disability must meet the same performance and production standards; whether quantitative or qualitative,** as a non-disabled employee in the same job, lowering or changing a production standard because an employee cannot meet it due to a disability is not considered a reasonable accommodation. Similarly, **an employee who is chronically, frequently and unpredictably absent may not be able to perform one or more essential functions of the job,** or the employer may be able to demonstrate that any accommodation would impose an undue hardship, thus rendering the employee unqualified. **Employers generally do not have to accommodate repeated instances of tardiness or absenteeism** that occur with some frequency over an extended period of time and often without advance notice. *The Americans with Disabilities Act: Applying Performance and Conduct Standards to Employees with Disabilities.*

Please return completed form to:

Human Resources; Weber County; 2380 Washington Blvd. Suite #340, Ogden, Utah 84401

OR

Fax to: 801-399-8307

VERIFICATION

(To be signed by the medical professional who has completed this form.)

I, the undersigned, affirm that I have provided the information above and that said information is true and correct to the best of my knowledge and belief.

Date: _____ Print name: _____

Signature: _____

Address: _____

Phone: _____

Fax: _____

Email: _____