

**COLLEGE OF CHARLESTON
MEDICAL INQUIRY FORM
IN RESPONSE TO AN ACCOMMODATION REQUEST**

TO BE COMPLETED BY THE EMPLOYEE'S HEALTH CARE PROVIDER

Notice to the Health Care Provider – Your patient is an employee at the College of Charleston and has requested an accommodation related to their physical and/or mental health condition. The purpose of this form is to assist the College of Charleston in determining whether the employee has a disability as defined by the Americans with Disabilities Act (“ADA”), as amended, and if so, whether and what type of reasonable accommodation the employee needs to perform the essential functions of their job and/or to access benefits of employment. Please review the job description and complete all sections of this form.

Employee Name

Job Title	Department
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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 an impairment. The following questions may help determine whether an employee has a disability:

Does the employee have a physical or mental impairment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, what is the impairment?

What is the medical diagnosis?

Date of diagnosis:

Expected duration of impairment:

Date of most recent visit:

Frequency of visits:

Please answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, what major life activity(s) is/are substantially limited?

<input type="checkbox"/> Bending	<input type="checkbox"/> Hearing	<input type="checkbox"/> Reaching	<input type="checkbox"/> Speaking	<input type="checkbox"/> Communicating
<input type="checkbox"/> Breathing	<input type="checkbox"/> Interacting With Others	<input type="checkbox"/> Reading	<input type="checkbox"/> Standing	<input type="checkbox"/> Other: (describe)
<input type="checkbox"/> Caring For Self	<input type="checkbox"/> Learning	<input type="checkbox"/> Seeing	<input type="checkbox"/> Thinking	
<input type="checkbox"/> Concentrating	<input type="checkbox"/> Lifting	<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking	
<input type="checkbox"/> Eating	<input type="checkbox"/> Performing Manual Tasks	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Working	

What major bodily function(s) is/are substantially limited?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Digestive | <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> Special Sense Organs & Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hemic | <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Circulatory | <input type="checkbox"/> Immune | <input type="checkbox"/> Operation of an Organ | |

B. 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 questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) in major life activities and/or bodily functions noted above is interfering with job performance or accessing a benefit of employment?

What job function(s) and/or benefit(s) of employment is the employee having trouble performing or accessing because of the limitation(s)?

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

What is the employee's planned course of treatment, including expected duration of treatment?

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 a 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 overcome limitations related to performing essential job functions or accessing benefits? If so, what are they?

How would your suggestions allow the employee to perform essential job functions or gain access to benefits?

D. Other questions or comments.

Medical Professional's Name:

Title:

Specialty:

Address:

Phone:

Fax:

Email:

Medical Professional's Signature

Date

Return this form to the Office of Equal Opportunity Programs at Robert Scott Small Building, Suite 115, by email at: eop@cofc.edu or fax at: (843) 953-1843. Any questions about this form can be directed to the Office of Equal Opportunity Programs at: (843) 953-5754.