

Accommodation Assessment Questionnaire New Request

Employee Name

Employer

Date Provided

Date Due

HEALTH CARE PROVIDER:

Your patient is requesting an accommodation under the Americans with Disabilities Act (ADA), as amended, and/or similar state and local laws, and your responses to the questions below will assist the employer in making a determination regarding the employee's request. Please be as specific as you can and provide your best estimate based on your medical knowledge, experience, and examination of your patient. Please limit your responses to the work restrictions or limitations that are applicable in the workplace, and for the period of time in which your patient is seeking an accommodation. These questions are designed to provide information as to the existence of a disability, effective accommodation options, or both. Please return this completed form to your patient so that it may be submitted by the due date. Thank you.

To ensure compliance with the federal and California Genetic Information Nondiscrimination Acts (GINA and CalGINA), please do not provide any genetic information when responding to this request. "Genetic information," as defined by law, includes an individual's family medical history, information regarding the manifestation of a disease or disorder in an individual's family member, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services or participated in clinical research that includes genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. "Genetic information" does not include information about the individual's sex or age.

- A. In your opinion, does the patient have a physical or mental impairment that could potentially limit their ability to perform a major life activity?
☐ YES ☐ NO
- B. In your opinion, does the impairment affect your patient's ability to perform the essential functions of their job? (*Refer to job description for the essential job functions*) ☐ YES ☐ NO
- C. What essential job function(s) do you believe is/are affected by the individual's condition? (*Refer to job description for the essential job functions*)
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D. Duration of Restrictions/Limitations:

1. Are your patient's restrictions/limitations long term or indefinite? ☐ YES ☐ NO

2. If not long term or indefinite, how long do you estimate an accommodation for your patient's restrictions/limitations will be needed?

Start Date: ____/____/____ Until Date (when restrictions are no longer in effect): ____/____/____
 [Month/Day/Year] [Month/Day/Year]

3. What are the restrictions/limitations that affect your patient's ability to perform their essential job functions? Use the lists below or add your own restrictions/limitations to describe details so that your patient's employer may clearly understand how to apply them:

Physical Restrictions: ☐ NO physical restrictions

- | | |
|--|---|
| ☐ NO repetitive lifting/carrying > ____ lbs.
for ____ times/hour | ☐ NO repetitive bending/stooping > ____ times/hour |
| ☐ NO lifting/carrying > ____ lbs. for ____ times/hour | ☐ NO repetitive squatting/kneeling > ____ times/hour |
| ☐ NO repetitive pushing/pulling > ____ lbs.
for ____ times/hour | ☐ NO prolonged standing in excess of ____ min./hour |
| ☐ NO pushing/pulling > ____ lbs. for ____ times/hour | ☐ NO prolonged sitting in excess of ____ min./hour |
| ☐ NO reaching above shoulders > ____ times/hour | ☐ Must alternate sitting/standing every ____ min./hour |
| ☐ NO repetitive keyboarding in excess of ____ minutes/hour | ☐ NO climbing/working at heights (circle your answer) |
| ☐ NO prolonged walking in excess of ____ minutes/hour | ☐ Other (please be specific) |
| ☐ NO driving > ____ minutes/hour | |

Cognitive Limitations: ☐ NO cognitive limitations

- | | |
|---|---|
| ☐ Relate to other people | ☐ Perform tasks requiring minimal intellectual effort |
| ☐ Perform daily activities, such as attend meetings,
communicate effectively with others, attend to personal
needs, etc. | ☐ Perform tasks requiring intellectually complex effort
such as higher levels of reasoning, math and
language skills |
| ☐ Understand, carry out and remember instructions | ☐ Perform repetitive tasks |
| ☐ Respond appropriately to supervision | ☐ Perform varied tasks |
| ☐ Perform work independently with minimal contact with
others | ☐ Make independent judgment |
| ☐ Perform work requiring regular contact and collaboration
with others | ☐ Supervise or manage others |
| | ☐ Provide direction or instructions to others |
| | ☐ Other (please be specific) |

E. Please check what type of accommodation(s) you are recommending for your patient:

What accommodations do you believe would allow the individual to perform each essential function? Please be specific. Examples of an accommodation may, depending on the circumstances, include, but are not limited to, a modified work schedule, modified work tools or equipment, or a leave of absence. (Please note that the employer retains the discretion to determine whether an accommodation is reasonable).

- ☐ **At-Work Accommodations** (An at-work accommodation will not involve time away from work as an accommodation; e.g. adaptive equipment, modified work schedule, etc.)

Start Date: ____/____/____ Until Date (when restrictions are no longer in effect): ____/____/____
 [Month/Day/Year] [Month/Day/Year]

Please describe any suggested workplace accommodations you believe would help the employee perform their job:

☐ **Intermittent Leave of Absence**

Start Date: ____/____/____ Until Date (when restrictions are no longer in effect): ____/____/____
 [Month/Day/Year] [Month/Day/Year]

• Office Visits/Treatment:

Frequency: _____ times per (CIRCLE ONE): Week Month

Duration: (COMPLETE ONE) _____ hour(s) OR _____ day(s) per appointment

• Incapacity:

Frequency: _____ times per (CIRCLE ONE): Week Month

Duration: (COMPLETE ONE) _____ hour(s) OR _____ day(s) per episode

☐ **Reduced Work Schedule Leave of Absence**

Start Date: ____/____/____ Until Date (when restrictions are no longer in effect): ____/____/____
 [Month/Day/Year] [Month/Day/Year]

Can work: _____ hours per day, _____ days per week

☐ **Continuous Leave of Absence**

Start Date: ____/____/____ Until Date (when restrictions are no longer in effect): ____/____/____
 [Month/Day/Year] [Month/Day/Year]

- If the restrictions/limitations you have identified on page 2 can be accommodated at work, can your patient continue to work? Why or why not?

F. Do you believe your patient's continued assignment to the job of [job title] poses a significant risk of harm to the health and safety of the employee or others?

- ☐ YES, proceed to questions G and H below.
☐ NO, complete question I below.

G. If there is a significant risk of harm to the health and safety of the employee or others, identify the nature, duration, severity, likelihood, and imminence of each specific risk.

H. If there is a significant risk of harm to the health and safety of the employee or others, identify any specific work restrictions(s) that, if accommodated, would reduce or eliminate the risk(s).

I. Please use the space below or additional paper to include any additional information or details that may be helpful in the interactive discussion process with your patient. Please attach additional paper, if necessary.

Office Address

Office Phone Number

Office Fax Number