ADA – Physician Questionnaire
Please print or type answers

Name of Patient/Employee: ____

1. Is the employee substantially limited in any major life activities as a result of his or her health condition? If so, please identify the major life activities. For each item you checkmark, please indicate the severity of the limitation and the manner in which the employee is restricted.

- ☐ Caring for oneself
- ☐ Walking
- ☐ Seeing
- ☐ Hearing
- ☐ Eating
- ☐ Performing manual tasks
- ☐ Working (only if entire types of jobs cannot be done)
- ☐ Driving
- ☐ Toileting
- ☐ Sleeping
- ☐ Concentrating
- ☐ Lifting
- ☐ Reaching
- ☐ Reading
- ☐ Speaking
- ☐ Standing
- ☐ Interacting with others
- ☐ Breathing
- ☐ Sitting
- ☐ Thinking
- ☐ Learning
- ☐ Bending
- ☐ Others (please describe)

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2. The job description and essential functions of the employee's job are enclosed with this Questionnaire. Based on your review of these, is the employee able to perform the essential functions of this position with or without reasonable accommodation? Yes _____ No _____

   If Yes, please go to question No. 3.

   If No:

   a. Please identify the functions of the employee's job that he or she is **unable** to perform.

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      ____
      ____
      ____
      ____

   b. How long will the employee be unable to perform these job duties?

      1 month ____ 3 months ____ 6 months ____ 1 year ____ unknown ____ permanently ____

3. Does the employee have a physical or mental impairment? Yes _____ No _____

   If Yes, what is the impairment?

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   ____
   ____

4. What limitations are interfering with job performance, and how do they interfere with the employee's ability to perform the essential job functions?

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5. If the employee's impairment is episodic in nature, please indicate the circumstances under which the symptoms occur.

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6. How long will the employee be limited in performing the life activity or activities as described above?

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   ____

   If unknown, will the employee need to take any leave? Yes ____ No ____

   If Yes, what is the likely duration? 1 month ____ 3 months ____ 6 months ____ 1 year ____

7. What adjustments or modifications to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

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8. The employee's current work schedule is ____. Would adjustments or modifications to the work schedule enable the employee to perform the essential functions of the job? If so, what changes would be necessary?

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   ____

9. How long would the employee need the accommodations you identified in your responses to questions 7 and 8 above?

   1 month ____ 3 months ____ 6 months ____ 1 year ____ unknown ____ permanently ____

   If you cannot provide a date, when will the employee be medically reevaluated? __________________
   ____

10. Does the employee require a leave of absence at this time? Yes ____ No ____

    If Yes, is the required leave continuous or intermittent? Continuous ____ Intermittent ____

    If continuous, would the employee's leave be indefinite? Yes ____ No ____

    If you answered No, please specify the time period and return to work date. ________________
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    ____
    ____

If intermittent, please specify the number of days per month or week that the employee would require a leave, as well as the period of time for which the intermittent leave is needed.

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11. In performing the essential functions of his or her job, in your opinion, would the employee pose a significant risk of substantial harm to the health or safety of the employee or others which cannot be eliminated by an accommodation? Yes ____ No ____

    If Yes, please state why.

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The individual named on page one is my patient. The information provided here is based upon my knowledge of the patient and the patient's physical or mental impairment.

Caregiver's Signature: ______________________________ Date: ____________________________

Printed Name: ___________________________________

Type of Practice: ________________________________

Contact Address and Phone: ________________________

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PLEASE RETURN TO SIGNER OF COVER LETTER IN THE ENVELOPE PROVIDED.