

MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

This form is to be completed by the employee's health care provider.

Employee: _____

Current Position: _____ Date: _____

The employee listed above has identified a medical condition that affects their employment. Please provide the following information to assist us with an evaluation of this employee's work capabilities. If you have any questions, please contact the Director of Operations at (413) 542-4012.

Please return this completed form in a sealed envelope to: Director of Operations, Five Colleges, Incorporated, 97 Spring Street, Amherst, MA 01002. Mark the envelope CONFIDENTIAL.

A. DISABILITY INFORMATION

1. Does the employee have a physical or mental impairment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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2. If yes, what is the impairment or the nature of the impairment? It is not necessary to provide a diagnosis.

Answer the following question based on what limitations the employee has when their 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.

3. Does the impairment substantially limit a major life activity as compared to most people in the general population?

Note: Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.

Yes No OR Describe the employee's limitations when the impairment is active.

4. If yes, what major life activity(s) (includes major bodily functions) is/are affected?

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

5. Major bodily functions:

- | | | | |
|--|--|--|--|
| <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"/> Circulatory | <input type="checkbox"/> Immune | <input type="checkbox"/> Operation of an Organ | |
| <input type="checkbox"/> Other (describe): | | | |

B. ACCOMMODATION INFORMATION

6. How does the employee's limitation(s) interfere with his/her ability to perform their job function(s)?

7. What suggestions, if any, do you have for possible accommodations to improve job performance?

8. How would these suggested accommodations improve the employee's job performance?

C. OTHER COMMENTS

Medical Professional

Signature

Date

Name

Address

Phone

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, 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, 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.