MEDICAL INQUIRY FORM
FOR EMPLOYEE ADA ACCOMMODATION REQUEST
(To be completed by Health Care Provider)

RETURN COMPLETED FORM TO: Diversity & EEO Office, Truth Hall, Room 103, 1700 E. Cold Spring Lane, Baltimore, MD 21251; Phone: 443-885-3559

Employee’s Name_________________________________ Job Title__________________

A. QUESTIONS TO HELP DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY

A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. The following questions may help determine whether an employee has a disability:

Does the employee have a physical or mental impairment? □ Yes □ No

What is the impairment/diagnosis? ________________________________________________

Is the impairment long-term or permanent? □ Yes □ No

If not permanent, how long will the impairment likely last? _________________

Does the impairment affect a major life activity? □ Yes □ No

If yes, what major life activity(ies) is/are affected?

☐ Caring for Self ☐ Walking ☐ Hearing ☐ Lifting
☐ Interacting with Others ☐ Standing ☐ Seeing ☐ Sleeping
☐ Performing Manual Tasks ☐ Reaching ☐ Speaking ☐ Concentrating
☐ Breathing ☐ Thinking ☐ Learning ☐ Working
☐ Bending ☐ Sitting ☐ Reading ☐ Eating
☐ Other: _______________________________________________________________________

Is the employee substantially limited in one or more of these major life activities? □ Yes □ No

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B. QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Which of the major life activities selected are interfering with the employee’s ability to perform the job functions?

________________________________________________________________________

________________________________________________________________________

What job function(s) is the employee having trouble performing because of the limitation(s)?

________________________________________________________________________

________________________________________________________________________

How does the employee’s limitation(s) interfere with his/her ability to perform the job function(s)?

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________________________________________________________________________

C. QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Please state any suggestions regarding possible accommodations to improve the employee’s ability to perform his/her job.

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________________________________________________________________________

How would your suggestions improve the employee’s ability to perform the job functions?

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________________________________________________________________________

D. ADDITIONAL COMMENTS

________________________________________________________________________

________________________________________________________________________

Physician’s Name (Please Print) _____________________________________________

Physician’s Signature: _______________________________ Date ________________

Phone: _______________________________ Fax: _______________________________