Lane Community College

Medical Inquiry Form / Accommodation Request

Employee Name: _____ Date: _____
Job Evaluated: _____

Please answer and return the following questionnaire as soon as possible. A self-addressed, stamped envelope is enclosed for your convenience. The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions, if needed, to answer more fully. Thank you for your anticipated cooperation.

IMPORTANT NOTE TO HEALTH CARE PROVIDER: When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

1. Does the employee have a physical or mental impairment? {circle one} Yes No

   If so, please state the diagnosis code and type of impairment: _____

2. Does the employee's impairment substantially limit any of his/her major life activities? {circle one} Yes No

   If so, which major life activity or activities are limited? _____

3. For each major life activity that is limited by the impairment, please describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity: _____

4. What is the duration or expected duration of the employee's impairment? _____

5. Attached is a job description for the employee's position. In addition to the attached job description, essential functions of this position also include the following:
   ☐ Being available and able to complete all required essential functions and assigned job tasks during the company's normal business hours of 8:00 a.m. – 5:00 p.m.
   ☐ Consistent and timely attendance.
   ☐ Other:

   **Once you have reviewed the job description and the list of additional, specific job functions above, please assess whether the employee can perform all of these job functions and explain below which functions, if any, s/he is not able to perform:

Employee is NOT able to perform the following job functions (identify the job functions and the reason why s/he is not able to perform that function). Please attach a separate sheet if more space is needed:

6. Please describe any accommodations that you believe would allow the employee to be able to perform the job functions listed above:

7. If medical leave is one of the possible accommodations listed above, please provide an estimated duration for the leave:

8. Would performing any of the job functions listed above and in the job description result in a direct safety or health threat to the employee or other people (co-workers, his/her supervisor, members of the general public, etc.)?

   {circle one} Yes No

   If yes, please describe:

   Which job functions would pose such a threat:

   The direct safety or health threat posed:

   Any recommended accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level:

Health Care Provider's Signature Title Date Signed

Health Care Provider's Printed Name Address

Please return completed form via confidential fax to (541) 463-3191. Thank you for your cooperation.