Human Resources
Administration and Finance

Medical Inquiry Form

To: Physician, or Treating Professional

RE: Employee: _____ Empl ID: _____ Date Provided to Employee: _____

The above employee has requested an accommodation based on a medical condition. The relevant portions of their job description is included in the chart below. Please complete the chart to best of your ability, and attach additional pages if necessary.

The University of Houston-Clear Lake (UHCL) requires diagnostic documentation from a licensed medical, psychological or other diagnostic professional (such as an audiologist for hearing impairments) when an employee is making a request for accommodations based on disability. It will benefit both the employee and UHCL for you to complete this form as specifically as possible. Feel free to attach any relevant supplementary documentation.

When answering the first five questions, please do not take into consideration any remedial 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 already in place, auxiliary aids or services, or learned behavioral or adaptive neurological modifications.

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. (75 Fed. Reg. 68934)

Please contact UHCL's Office of Human Resources at (281) 283-2160, if you have any questions about completing this form. Your assistance is greatly appreciated!

Please return directly to: **Office of Human Resources, 2700 Bay Area Blvd., Houston, TX 77058**
Fax: 281-283-2158

1. Diagnosis/es: _____
2. Does the employee have a physical or mental impairment? ◯ Yes ◯ No
3. What is the impairment? _____
4. Is the impairment: ◯ **Short Term** ◯ **Long Term** ◯ **Permanent**
   a. If **not** permanent, how long will the impairment likely last?
   _____
5. Does the employee's impairment substantially limit any major life activities? ◯ **Yes** ◯ **No**
   a. If so, which major life activities are limited and how are they limited:
   _____
6. Etiology (cause) of condition(s):

_____

_____

7. Is this condition(s) degenerative? ◯ **No** ◯ **Yes** **If Yes**, please elaborate.

_____

_____

Following are essential functions, duties and physical requirements of this employee's job. Please evaluate his/her ability to perform each function and to meet each requirement without accommodation of any kind. UHCL will then determine, with input from the employee, whether any accommodations are needed and if so, what is reasonable.

Rating Code:

1 = no limit on employee's ability to perform
2 = partial limit on employee's ability to perform (explain)
3 = employee cannot perform this function (explain)
0 = unable to rate

Job Title: _____

Job Summary:

Job Duties	Rating	Accommodation Suggestions/Comments

_____ _____ _____

Physician's Signature | Typed or Printed Name of Physician | Title

_____ _____ _____

Print Physician's Office Address | Physician's Telephone Number(s) | Date Form Was Completed