University of Houston Clear Lake

MEDICAL INQUIRY FORM

Employee Name: _____

The above employee has requested an accommodation based on a medical condition. Attached is a copy of the employee's job description. Please review the essential job functions as indicated by an asterisk (*) in the first column of the job duties. In answering the following questions, address any limitation(s)/restriction(s), if any that may exist in the employee's performance of those job functions due to his/her medical condition. If you identify any limitation(s)/restriction(s), please provide suggestions for possible accommodations you believe may allow the employee to perform his/her essential job functions. Attach a separate sheet, if necessary. (NOTE: Please attempt to use the same language contained in the job description when addressing specific limitations.)

Suggested Documentation Elements:

1. Typed on letterhead, dated, and signed by a qualified professional.
2. Diagnostic statement with any related diagnostic methodology. Examples: diagnostic criteria, procedures, assessment instruments, and/or test scores.
3. Functional limitations or symptoms. Limitations identify which accommodations are appropriate.
4. Severity and/or expected progression.
5. Current medication(s) and any related side-effects.
6. Any other relevant information and/or additional information regarding the condition.
7. Current and/or past accommodations.
8. Any recommended accommodations.

When answering the first three 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 or 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 the University of Houston-Clear Lake's ADA Coordinator if you have any questions about completing this form:

Title IX/Equity and Diversity Office
2700 Bay Area Boulevard
Houston, Texas 77058-1098
Email: titleix@uhcl.edu
Phone: 281.283.2305

University of Houston Clear Lake

MEDICAL INQUIRY FORM
(to be completed by doctor)

1. Does the employee have a physical or mental impairment?

☐ **No** ☐ **Yes** What is the impairment? _____

2. Is the impairment: ☐ **Short Term** ☐ **Long Term** ☐ **Permanent**

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

3. Does the employee's impairment substantially limit any major life activities?

☐ **No** ☐ **Yes**

If so which major life activities are limited?

_____

_____

_____

4. After reviewing the employee's job description, can the employee perform all of his/her essential job functions?

☐ **No** ☐ **Yes**

If not, which of the essential functions of his/her job would require modification?

_____

_____

_____

5. List suggestions, if any, you may have regarding possible accommodations to allow the employee to perform his/her essential job functions.

_____

_____

_____

_____ _____

SIGNATURE LICENSED HEALTH CARE PRACTITIONER **PRINTED NAME**

_____ _____

AREA OF SPECIALIZATION AND LICENSE NUMBER **DATE**

_____ _____

PHONE **FAX**

_____ _____

ADDRESS **EMAIL**