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| **Medical Inquiry Form in Response to an Accommodation Request** | | | | | | |
| **This section should be completed and signed by the Employee.** | | | | | | |
| Employee Name |  | | EMPLID | |  | |
| UTSA Email |  | | Work Number | |  | |
| Personal Email |  | | Personal Number | |  | |
| Department |  | | Job Title | |  | |
| Signature |  | | Date | |  | |
| **The following questions should be completed and signed by the Provider.** | | | | | | |
| 1. **Questions to help determine whether an employee has a disability**   For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability. | | | | | | |
| Does the person have a physical or mental impairment? | | | | Yes  No | | |
|  | | | | | | |
| Is the impairment permanent? | | | | Yes  No | | |
|  | | | | | | |
| Does the impairment substantially limit a major life activity? | | | | Yes  No | | |
|  | | No Impact | | Moderate Impact | | Substantial Impact |
| Balancing | |  | |  | |  |
| Bending | |  | |  | |  |
| Breathing | |  | |  | |  |
| Care for Self | |  | |  | |  |
| Communicating | |  | |  | |  |
| Concentrating | |  | |  | |  |
| Driving | |  | |  | |  |
| Dietary Needs | |  | |  | |  |
| Hearing | |  | |  | |  |
| Interacting with others | |  | |  | |  |
| Learning | |  | |  | |  |
| Lifting | |  | |  | |  |
| Performing manual tasks | |  | |  | |  |
| Reaching | |  | |  | |  |
| Reading | |  | |  | |  |
| Running | |  | |  | |  |
| Sitting | |  | |  | |  |
| Sleeping | |  | |  | |  |
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| Employee Name | |  | | EMPLID | |  |
|  | |  | |  | |  |
|  | | No Impact | | Moderate Impact | | Substantial Impact |
| Speaking | |  | |  | |  |
| Standing | |  | |  | |  |
| Thinking | |  | |  | |  |
| Vision | |  | |  | |  |
| Walking | |  | |  | |  |
| Other (Describe): | |  | | | | |
|  | | | | | | |
| Major Bodily Functions affected | | No Impact | | Moderate Impact | | Substantial Impact |
| Bladder | |  | |  | |  |
| Bowel | |  | |  | |  |
| Brain | |  | |  | |  |
| Cardiovascular | |  | |  | |  |
| Circulatory | |  | |  | |  |
| Digestive | |  | |  | |  |
| Endocrine | |  | |  | |  |
| Genitourinary | |  | |  | |  |
| Hemic | |  | |  | |  |
| Immune | |  | |  | |  |
| Lymphatic | |  | |  | |  |
| Musculoskeletal | |  | |  | |  |
| Neurological | |  | |  | |  |
| Normal Cell Growth | |  | |  | |  |
| Operation of an Organ | |  | |  | |  |
| Reproductive | |  | |  | |  |
| Respiratory | |  | |  | |  |
| Special Sense Organs | |  | |  | |  |
| Other (Describe): | |  | | | | |

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| **B. Questions to help determine whether an accommodation is needed**  A person with a disability is entitled to accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability. |
| Which limitation(s) interfere(s) with the employee's ability to perform the essential functions of the position? |
| What job function(s) is the employee having trouble performing or accessing because of the impairment(s)? |
| Describe, in detail, how the employee's impairment(s) substantially interfere(s) with the major life activity of "working," that is, the employee's capacity to perform the essential functions of their position. |
| **C. Questions to help determine effective accommodation options**  The following questions may help determine effective accommodation(s) if the employee is determined to be disabled. |
| Taking into consideration; the nature, severity, and duration of the impairment, the limitations imposed by the impairment, and the effect of the impairment on the employee's ability to perform the essential functions of the position, what alterations to the employee's duties, if any, may assist the employee in effectively performing the essential functions of the position? (e.g. alternative scheduling, use of accrued paid leave or additional paid leave, scheduled breaks, adaptive equipment, movement/effort restrictions, physical changes to the workplace or equipment, etc.) |
| What, if any, auxiliary aids/or services may assist the employee in effectively performing the essential functions of the position? (e.g. screen readers, sign language interpreters, assistive devices, etc.) |

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| **D. Other Comments** | |
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| **Medical Provider Name:** |  |
| **Address:** |  |
| **Telephone:** |  |
| **Medical Provider Signature:** |  |
| **Date:** |  |

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| Please submit this complete form by one of the following methods. |
| **Email:** [ADA@utsa.edu](mailto:ADA@utsa.edu)  **Fax:** 210-458-4644  **USPS Mail:**  The University of Texas at San Antonio  People Excellence  Attn: ADA  One UTSA Circle  San Antonio, Texas 78249 |
| *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.* |