ADA Interactive Process Health Care Provider Questionnaire

-To be completed by a physician or qualified health care provider-

To Health Care Provider: Please complete this form in full. This questionnaire is part of an interactive process that is necessary in order to determine if your patient (our employee) has a disability recognized under the Americans with Disabilities Act, and, if so, what, if any, reasonable accommodation(s) are necessary and can be made that would enable your patient to perform the essential functions of his or her job. Please review the job description provided prior to completing this form.

NOTE: When answering the questions in Section A below, please assess the patient's condition without regard to the ameliorative effects of mitigating measures, such as medication, medical supplies or equipment, prosthetics, assistive technology, reasonable accommodations or auxiliary aids, or behavioral or adaptive neurological modifications.[1]

Employee/Patient Name: _____

SECTION A: PATIENT INFORMATION

1. Does this patient have a physical or mental impairment? _____Yes _____No
   If so, please identify/state the impairment. _____

_____

_____

2. When did the patient first experience this medical condition(s) (approximate date/year)?_____

   What is the expected duration of the patient's medical condition(s)? (Is the condition permanent or temporary? If temporary, what is the expected duration of the condition?)

_____

_____

3. In your medical opinion, does the patient's medical condition limit his or her ability to perform any major life activities? (Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, sitting, reaching, and the operation of major bodily functions, such as functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.)
   _____Yes _____No

   If "Yes," please list all major life activities that are limited by his or her medical condition. If "No," you need not answer any further; just provide the Certification information at the end of page 2.

Employee's Affected Major Life Activities:

- ☐ Seeing
- ☐ Hearing
- ☐ Speaking, Communicating
- ☐ Eating
- ☐ Sleeping
- ☐ Working**
- ☐ Walking, Standing, Lifting, Bending
- ☐ Breathing
- ☐ Performing Manual Tasks
- ☐ Learning, Reading, Concentrating, Thinking
- ☐ Caring for Self
- ☐ None

Employee's Affected Major Bodily Functions:

- ☐ Immune System
- ☐ Endocrine
- ☐ Respiratory
- ☐ None
- ☐ Digestive, Bowel, Bladder
- ☐ Neurological, Brain
- ☐ Circulatory

4. What type of workplace activities or job functions is the patient unable or limited in his/her ability to perform, if any? Please describe how and the extent to which the patient's physical or mental impairment substantially or significantly limits his or her ability to perform workplace activities or job functions. If no limitations or restrictions, state so.

Restrictions or Limitations	**Frequency/Duration**	**Severity (Mild/Moderate/Severe)**

5. Please describe the expected duration of each limitation listed in the answers above (as distinguished from the duration of the condition itself). Please provide specifics to the extent possible (e.g., number of days, weeks, or months).

6. Do you consider any of the patient's limitations to be temporary and non-chronic? If so, which ones?

7. In your medical opinion, for each major life activity identified, is the patient materially (less than significantly but more than moderately) restricted in his or her ability to perform that activity, as compared to the ability of an average person in the general population? If so, please explain.

SECTION B: ACCOMMODATIONS

1. Do you know of any job modification(s) or other accommodation(s) that would enable the patient to perform the job functions you identified?

_____Yes _____No

If "Yes," please describe in detail the suggested modification(s) or other accommodation(s).

2. Does the patient need a leave of absence for the condition? _____Yes _____ No

☐ **Continuous** – absence that is three days or longer in a single occurrence.

Start/Anticipated start date: _____ End/anticipated end date: _____

☐ **Intermittent** – absence has periodic occurrences with time worked between absences.

Start/Anticipated start date: _____ End/anticipated end date: _____

Episodes of incapacity are estimated to occur _____times per ☐ day ☐ week ☐ month and are likely to last approximately _____ ☐ hours ☐ days per episode

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[1] The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers 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 service.

3. Please describe the manner by which the suggested job modification(s), other work accommodation(s), and/or leave of absence would enable your patient to perform the affected job functions.

_____

_____

_____

_____

4. Is the patient taking any medication(s) or undergoing any treatments that affect the patient's ability to perform one or more functions of his/her job?

_____Yes _____No

If "Yes," please explain such effects and list any and all job restrictions you recommend.

_____

_____

_____

CERTIFICATION OF PHYSICIAN/HEALTH CARE PROVIDER

I hereby certify that all of the foregoing information is true and correct.

Signature of Provider: _____
Printed Name of Provider: _____
Area of Practice / Specialty: _____
Date Signed: _____
Telephone Number of Provider:_____Fax Number of Provider: _____
Address of Provider:_____

Please return the completed form to USF Central Human Resources, Attention: ADA:

Fax: 813-974-5227 Mail/Hand Delivery: 4202 E. Fowler Ave., SVC 2172
Email: HR-ADA-Request@usf.edu Tampa, FL 33620