Medical Response Form for Reasonable Accommodation

This form is intended to assist Arizona State University in understanding an employee's functional limitations and determining whether reasonable accommodation under the Americans with Disabilities Act may be appropriate. The information provided will be used as part of the interactive process between the employee and the university.

Instructions for employees

Do not return this form to your manager or anyone in your department. Submit this form using the online workplace accommodation portal.

Instructions for health care providers

Employees who qualify for reasonable accommodation under the ADA must have a disability or impairment that substantially limits one or more major life activities or a record of such impairment. Please answer the following questions, which help determine whether the employee is a qualified individual with a disability, and if so, how the limitations affect the employee's ability to complete the essential job functions that necessitate reasonable accommodation.

Please complete this form based on your professional knowledge of the employee's condition and its impact on their ability to perform the essential functions of their position.

To avoid delays in the accommodation review process, please complete this form and return it to the employee within 14 calendar days whenever possible.

Employee or patient name:

_____

Employee job description reviewed? ☐ Yes ☐ No

1. Is the request related to pregnancy, childbirth, lactation, or a related medical condition?
   ☐ Yes ☐ No
2. Does the employee have a physical or mental impairment? ☐ Yes ☐ No

If yes, what functional limitations result from the employee's condition that impact the performance of essential job functions?

3. Does the impairment substantially limit a major life activity? ☐ Yes ☐ No

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Other: Describe in comment.
☐ Breathing	☐ Interacting with others	☐ Reading	☐ Standing	
☐ Self-care	☐ Learning	☐ Seeing	☐ Thinking	
☐ Concentration	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing manual tasks	☐ Sleeping	☐ Working	

Comment:

4. Is the condition ☐ Chronic ☐ Episodic ☐ In remission (Check all that apply)
   Please explain:

If the impairment is episodic, how frequently is it expected to occur?

5. Which essential job functions are impacted by the employee's functional limitations? Please describe how these limitations affect the employee's ability to perform those functions.

Employee or patient name:
_____

6. What workplace accommodation, if any, may assist the employee in performing the essential functions of their position? Describe the connection between the accommodation and the functional limitation. Please be as specific as possible.

7. How long will the employee need the accommodation? Select one.

☐ Less than 30 days
☐ 30–90 days
☐ More than 90 days
☐ Indefinitely or ongoing

Estimated end date, if known: _____

8. If the employee is requesting leave, please complete the following questions:

a) Why does the employee need a leave of absence?

b) How much leave will the employee need?

What are the approximate dates for the leave?

9. Please provide any other information that might help ASU evaluate this request.

Employee or patient name:

The information provided describes the employee's functional limitations and potential accommodation needs. ASU will determine, through the interactive process, whether the employee is eligible for accommodation and, if so, what accommodation, if any, is reasonable and appropriate.

I am a licensed health care provider in a jurisdiction of the United States.

By signing below, I affirm the following:

- I am the treating health care provider for the above-named employee and have examined the patient and reviewed their medical records to sufficiently evaluate the request for a workplace accommodation.
- The above information is true and accurate and supports the above-named employee's request for a workplace accommodation.
- I understand that I might be required to submit additional supporting medical documentation.

Healthcare provider name (printed): _____

Specialty: _____

NPI number: _____ License number: _____State of Licensure: _____

Practice name: _____

Address: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

Office stamp:

Genetic Information Nondiscrimination Act of 2008

Title II of the Genetic Information Nondiscrimination Act prohibits employers and other entities from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. In compliance with the law, please do not provide any genetic information when responding to this request for medical information. Visit the Equal Employment Opportunity Commission webpage for more details on the GINA, including definitions of genetic information.

Employee or patient name:

_____