MEDICAL INQUIRY IN RESPONSE TO
AN ADA ACCOMMODATION REQUEST

WestVirginiaUniversity.
OFFICE OF COMPLIANCE AND
PREVENTION EDUCATION

## Employee Information

| | |
|---|---|
| Employee's Name: | Date of Birth: |
| Home Address: | |
| Home Phone Number: | Office Phone Number: |
| Email: | Supervisor: |
| Department: | Job Title: |

## Medical Inquiry-To be Completed by a Medical Professional

**A. 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 employee have a physical or mental impairment? | Yes ☐ | No ☐ |

If *yes*, what is the impairment or the nature of the impairment?

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_____

Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

| | | |
|---|---|---|
| Does the impairment substantially limit a major life activity as compared to most people in the general population? | Yes ☐ | No ☐ |

OR

Describe the employee's limitations when the impairment is active.

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_____

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_____

*Note: Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.*

If *yes*, what major life activity(s) (includes major bodily functions) is/are affected?

| | | | | |
|---|---|---|---|---|
| ☐ Bending | ☐ Hearing | ☐ Reaching | ☐ Speaking | ☐ Other: (describe) |
| ☐ Breathing | ☐ Interacting with Others | ☐ Reading | ☐ Standing | _____ |
| ☐ Caring for Self | ☐ Learning | ☐ Seeing | ☐ Thinking | _____ |
| ☐ Concentrating | ☐ Lifting | ☐ Sitting | ☐ Walking | _____ |
| ☐ Eating | ☐ Performing Manual Tasks | ☐ Sleeping | ☐ Working | _____ |

Major bodily functions:

| | | | |
|---|---|---|---|
| ☐ Bladder | ☐ Digestive | ☐ Lymphatic | ☐ Reproductive |
| ☐ Bowel | ☐ Endocrine | ☐ Musculoskeletal | ☐ Respiratory |
| ☐ Brain | ☐ Genitourinary | ☐ Neurological | ☐ Special Sense Organs & Skin |
| ☐ Cardiovascular | ☐ Hemic | ☐ Normal Cell Growth | ☐ Other: (describe) |
| ☐ Circulatory | ☐ Immune | ☐ Operation of an Organ | |

**B. Questions to help determine whether an accommodation is needed.**

An employee with a disability is entitled to an 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:

What limitation(s) is interfering with job performance or accessing a benefit of employment?

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_____

_____

What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?

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_____

_____

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

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**C. For Questions related to COVID-19 specific Accommodations. If not applicable, please skip to section D.**

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. According to the Centers for Disease Control and Prevention (CDC), individuals with certain conditions or factors may have a higher risk for severe COVID-19 infection.

| | | |
|---|---|---|
| Is the employee's accommodation need specific to the COVID-19 pandemic? | Yes ☐ | No ☐ |
| Does the use of a COVID-19 vaccine negate the need for future COVID-specific accommodations? | Yes ☐ | No ☐ |

| If a COVID-19 vaccine was provided, was the vaccine effective? | Yes ☐ | No ☐ |
|---|---|---|

Do you have specific recommendations for the employee related to COVID-19 ?

| | | |
|---|---|---|
| ☐ Plexiglass barriers | ☐ Alternative PPEs (face shield, gloves, etc.) | ☐ Remote environment/telework |
| ☐ Physical distancing | | ☐ Hybrid work environment |
| ☐ Remote meetings | ☐ Reduced capacity environments | ☐ Modified training or instructional methods |
| ☐ Additional cleaning supplies | ☐ Rotating shifts to limit exposure | |

Other-Please describe:

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**D. Questions to help determine effective accommodation options.**

Do you have any suggestions regarding possible accommodations to improve job performance?

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How would your suggestions improve the employee's job performance?

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**D. Other information or comments.**

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Medical Professional's Signature: Date:

_____

Medical Professional's Name (Print)

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.

PLEASE RETURN THIS FORM BY FAX TO 304-293-8279.