Agency Logo

Human Resources / Division / Unit

**Questionnaire for Health Care Provider**

**A few helpful tips for HR staff. Please delete this first page before sending to health care provider.**

On this document, you will see some questions that may be asked from the employee’s health care provider. You do not need to ask all of the questions listed. Based on the specific situation, you can customize the questions listed or you can add other questions as necessary.

* It is helpful to discuss the employee’s request with the employee and their supervisor before drafting these questions. This approach will enable you to:
  + Determine if you need to get additional information from the health care provider. (Sometimes you may not need more information).
  + Get a better understanding of the employee’s needs and the challenges they experience in the workplace as well as potential accommodations to explore.
* If you determine you need additional information from the health care provider, you can draft the questions and ask the employee to have their health care provider complete this form.
* Select only the questions that will be helpful in the interactive process. A lengthy questionnaire often delays the responses from the health care provider.
* Make it as easy as possible for the health care provider to complete. You can choose Yes or No questions. You can provide the health care provider with spaces to insert their answers.
* If you do send the questionnaire (instead of having the employee deliver the questionnaire), contact the office of the doctor to confirm receipt.
  + Give the health care provider a deadline by which to respond. But keep in mind that the interactive process may not be stopped because a health care provider did not respond by the deadline.
* Enlist the help of the employee to elicit or expedite responses from their health care provider.

**Questions:**

1. Does the employee have a physical or mental impairment which impacts their ability to perform the essential functions of their job?

Yes\_\_\_\_\_ No\_\_\_\_\_\_

1. If yes, please describe the type of impairment and the impact on their job duties: (Please refer to the employee’s position description, which is attached.)

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1. Does the physical or mental impairment substantially impact a major life activity?

Yes\_\_\_\_\_ No\_\_\_\_\_\_

1. What is the duration or expected duration of the employee’s impairment?

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1. Please review the position description before answering this question. Is the employee able to perform all of the essential job functions outlined in the attached position description of the position title **without** an accommodation? Yes\_\_\_\_\_ No\_\_\_\_\_\_

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1. If not, which essential job function(s) CANNOT be performed without an accommodation? (Please attach additional pages if necessary)

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1. One of the goals of this interactive process is to elicit as many potential accommodation ideas and select one that is effective for the employee and that does not represent an undue hardship for the Agency. Please describe any reasonable accommodations that would enable the employee to perform all of the essential functions of their position. (Please attach additional pages if necessary)

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1. Please add any other information that would help us determine the limitations (Employee’s name) experiences as a result of their condition.

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**Health Care Provider’s Certification of Accuracy**

The signature below indicates that the information provided is an accurate reflection of the employee’s health condition and accommodations requested under the Americans with Disabilities Act. (ADA).

Printed Name of Health Care Provider

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Signature Date

Last revision: September of 2020