ADA Medical Inquiry Form

Limited Release of Medical Information

My signature below indicates my limited release of medical information to my employer, St. Vrain Valley Schools, as requested in this letter and as is necessary to assess the availability of reasonable accommodation to me at work.

_____
Employee printed name

_____ _____
Employee signature Date

Date: _____

Health Care Provider: _____

Employee Name: _____

Completed Form Must Be Returned to Employer By: _____
Form may be sent via confidential fax: 303-682-7399

Dear Provider,

The St. Vrain Valley School District is requesting that you provide information regarding two general issues: (a) whether your patient listed above has a physical or mental impairment that substantially limits one or more major life activities, including any functional limitations associated with such impairment(s), and (b) whether the impairment limits his or her ability to perform essential job functions, and suggested accommodations that would enable him or her to perform the essential functions of the _____ position.

Please respond fully and completely to the questions below. Do not provide information that is not related to the employee's ability to perform essential job functions. Attach additional information if necessary. In completing this form, you must provide your best medical judgement, based on current information.

1. Does the employee have a physical or mental impairment? Please evaluate the employee as if the medical condition was in an active state and without the benefits of medication or other mitigating measures, except ordinary eyeglasses or contact lenses. □ Yes □ No
2. If yes, please list the impairment: _____
3. Does the impairment affect a major life activity? □ Yes □ No

4. If yes, check any major life activity or major bodily function that is affected:

Major life activity:

□ Bending □ Hearing □ Reaching □ Speaking □ Other (describe)

□ Breathing □ Interacting with others □Reading

□ Standing □ Sitting □ Learning □ Seeing

□ Thinking □ Concentrating □ Lifting □ Caring for self

□ Walking □ Eating □Sleeping □ Working

□ Performing Manual Tasks

Major bodily functions:

□ Bladder □ Bowel □ Brain □Cardiovascular □ Other (describe)

□ Circulatory □ Digestive □ Endocrine □ Genitourinary

□ Hemic □ Immune □ Lymphatic □ Musculoskeletal

□ Neurologic □ Reproductive □ Respiratory □ Normal Cell Growth

□ Operation of an Organ □ Special Sense Organs & Skin

5. If yes, is the employee's ability to perform the major life activity or major bodily function substantially limited by the impairment compared to an average person in the general population? Substantial limitation means that the employee is restricted as to the condition, manner, or duration under which he or she performs the activity. □ Yes □ No
6. Please indicate how long you anticipate this impairment will substantially limit the major life activity or major bodily function.

7. Please review the attached job description for the _____ position for a description of the essential functions and additional requirements of that position. Please contact the District's ADA Coordinator at 303-682-7428 with any questions about the employee's job. Does the employee's impairment substantially limit the ability to perform the essential job functions identified in the attached job description?

   □ Yes □ No
8. If yes, what essential job functions are substantially limited?

9. How does the impairment substantially limit the employee's ability to perform the essential job functions?

10. Can you identify a reasonable accommodation that may enable the employee to perform the essential job function(s)? Examples of potential accommodation include restructuring a job, modification of work tools or equipment, a modified work schedule, or provision of qualified readers or interpreters. □ Yes □ No
11. If yes, please provide specific examples of accommodations that may enable the employee to perform he essential job function(s), or that may overcome an identified barrier in the workplace associated with the impairment.

12. How will the accommodation assist the employee to perform the essential job function(s)?

13. How long do you anticipate the employee will need the accommodations?

14. If the accommodation is a leave of absence, will a leave of absence assist the employee to return to work? □ Yes □ No
15. How will a leave of absence assist the employee in returning to work?

16. What dates do you anticipate the employee will need leave? Please provide your best medical judgement, based on current information, as to the length of leave.

17. If a leave of absence is granted, what is the likelihood that the employee will be able to return at the end of the leave?

Thank you for your professional attention to this matter. Please assist us further by signing below to indicate that you have personally evaluated the employee and reviewed the attached job description.

_____ _____

Health Care Provider Signature Date

_____ _____

Printed Name and Title Name of Practice/Clinic

_____

Phone number to call with questions or for clarification