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ACCOMMODATION REQUEST: MEDICAL INQUIRY FORM

This form is to be used by a MCSD employee to request medical information from his/her healthcare provider.

TO BE COMPLETED BY THE EMPLOYEE:

The employee named below hereby consents and agrees that their treating healthcare provider may complete this medical questionnaire and that the employee's private medical information may be released to the employer, Muscogee County School District.

Your healthcare provider may require that you also sign a HIPAA Authorization form to release certain medical information. You have an obligation to cooperate in the interactive accommodation process, including authorizing the release of medical information necessary to evaluate a request for accommodation.

Name: Title:

Date of Hire: Supervisor:

School/Location/Department:

Phone: Email:

Brief description of the requested accommodation:

Signature of Employee:_____Date: _____

Type of Disability:

☐ Physical ☐ Psychological

If medically related, do you have a note from your Health care Provider? ☐ Yes (Please attach) ☐ No

If you have sought assistance from your supervisor or any other person, please provide the date and results:

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TO BE COMPLETED BY HEALTHCARE PROVIDER:

INSTRUCTIONS TO THE HEALTHCARE PROVIDER: The above-named employee is currently employed by MCSD. The employee has reported a disability and has requested an accommodation. We currently are engaged in a dialogue with the employee regarding the employee's request for an accommodation pursuant to the Americans with Disabilities Act ("ADA").

Please do not provide any information beyond what is necessary to make this assessment. Furthermore, please do not provide information relating to any medical condition that does not require an accommodation.

As directed by the ADA, you should assess the ability of the individual to perform a major life activity as compared to most people in the general population. Do not consider mitigating measures (for example, hearing aids), with the exception of ordinary eyeglasses or contact lenses. If the impairment is episodic or in remission, evaluate whether the impairment would substantially limit a major life activity when active.

1. Does the employee have a physical, mental/psychological, and/or learning disability, including pregnancy, a pregnancy- related condition, and/or breastfeeding an infant child?

   Definition: A "disability" is defined as a physical disability, infirmity, malformation or disfigurement which is caused by bodily injury, birth defect or illness including epilepsy and other seizure disorders, and which shall include, but not be limited to, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment or physical reliance on a service or guide dog, wheelchair, or other remedial appliance or device, or any mental, psychological or developmental disability, including autism spectrum disorders, resulting from anatomical, psychological, physiological or neurological conditions which prevents the normal exercise of any bodily or mental functions or is demonstrable, medically or psychologically, by accepted clinical or laboratory diagnostic techniques. Disability shall also mean AIDS or HIV infection.

   ☐ Yes ☐ No

   If yes, please answer all of the questions on the next pages.

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2. Please describe the employee's disability:

3. Is the employee's disability temporary or permanent?
   ☐ Temporary ☐ Permanent

   If the answer is "temporary," give the approximate duration of the limitation imposed by the employee's disability.

4. Does the disability substantially limit the employee's ability to perform any of the employee's daily life activities? ☐ Yes ☐ No

   If yes, describe how:

   Check any major life activity substantially limited:

☐ Caring for oneself	☐ Performing manual tasks	☐ Seeing
☐ Hearing	☐ Eating	☐ Sleeping
☐ Walking	☐ Standing	☐ Lifting
☐ Bending	☐ Speaking	☐ Breathing
☐ Learning	☐ Reading	☐ Concentrating
☐ Thinking	☐ Communicating	☐ Working
☐ Sitting	☐ Reaching	☐ Interacting with others
☐ Operation of a major bodily function (see below)	☐ Other (Please describe):	

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If applicable, check any major bodily function that is substantially limited:

☐ Immune system	☐ Special sense organs and skin	☐ Normal cell growth
☐ Digestive functions	☐ Genitourinary functions	☐ Bowel functions
☐ Bladder functions	☐ Neurological functions	☐ Cardiovascular functions
☐ Endocrine functions	☐ Hemic functions	☐ Lymphatic functions
☐ Musculoskeletal functions	☐ Reproductive functions	☐ Operation of an individual organ:

☐ Other:

Explain how the individual's impairment substantially limits any major life activity identified above:

5. Does the disability affect the employee's ability to perform any of the employee's job functions?
   ☐ Yes ☐ No
   If yes, describe how:

6. Does this employee have difficulty accessing an employment benefit? ☐ Yes ☐ No
   If yes, please explain:

7. Are there ways in which MCSD could reasonably accommodate the employee that would enable the employee to fully perform the essential job functions of the employee's position? ☐ Yes ☐ No
   If yes, describe the proposed accommodation(s):

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8. Please feel free to offer any other comments or observations that you feel are important for the District to understand the employee's disability-related restrictions/limitations and/or the employee's ability to perform the essential functions of their job in light of those restrictions/limitations.

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.

Healthcare Provider (please print):_____ Specialty: _____

Address:_____ Phone: (_____)_____

Signed:_____ Date:_____

Please return this form to:

Division of Human Resources
2960 Macon Road, Columbus, GA 31906
P: (706) 748-2015 F: (706) 748-2039