MEDICAL QUESTIONNAIRE
For Reasonable Accommodation Request

This form is to be completed by the medical provider of a City of Chicago employee, job applicant, or volunteer. Please be as detailed as possible in your answers. **Please fax the completed form to the Disability Officer, at (312)744-9710**. You may attach additional paper if more room is needed to fully answer a question. Please sign and date all pages attached to this form. If you have any questions, please call the Disability Officer, at (312)744-4969.

YOUR PATIENT - - OUR EMPLOYEE/APPLICANT/VOLUNTEER

Name:	
Job Title:	Date of Birth:
Home Phone:	Work Phone:
Department:	Bureau/Division:

QUESTIONS TO DOCUMENT THE REASON FOR THE REQUEST

Does the employee/applicant/volunteer have a physical or mental impairment? If so, please **identify and describe** the physical or mental impairment. And "impairment" could include an injury to the human body.

_____
_____
_____
_____
_____

Based on reasonable medical certainty, is the impairment permanent?

_____ Yes _____ No

If "No", please state the length of anticipated duration and/or prognosis: _____

Does the physical or mental impairment, when active, substantially limit a major life activity or a major bodily function of the employee/applicant/volunteer?

_____ Yes _____ No

If "Yes", please identify all major life activities or bodily functions that are limited by using the check boxes below:

Major Life Activities: Please check all that apply. Use the space below to list any major life activities not listed.

_____ Eating
_____ Standing
_____ Walking
_____ Breathing
_____ Seeing
_____ Pushing
_____ Reaching
_____ Sitting
_____ Lifting
_____ Bending
_____ Concentrating
_____ Learning
_____ Speaking
_____ Hearing

Other:_____
_____
_____
_____
_____
_____
_____

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Major Bodily Functions: Please check all that apply

_____ Immune System	_____ Special Sense Organs and Skin
_____ Bowel	_____ Normal Cell Growth
_____ Bladder	_____ Digestive
_____ Neurological	_____ Genitourinary
_____ Respiratory	_____ Cardiovascular
_____ Circulatory	_____ Endocrine
_____ Lymphatic	_____ Hemic
_____ Musculoskeletal	_____ Reproductive Functions

Other:_____
_____
_____
_____
_____
_____
_____

Does the impairment interfere with the employee/applicant/volunteer's ability to perform his/her job or access an employment benefit?

_____ Yes _____ No

If "YES", please **indicate which job functions are restricted** and how the restriction interferes with the ability to perform the job or access an employment benefit.

Work Restriction	**Yes or No**	**Limitation**	**Specify Time/Weight/Degrees**
Example: Exposure to heat or cold	**Yes**	**Cannot be exposed to extremely cold temperatures**	**Max exposure – 15 minutes when the temperature is less than 20 F.**
Keyboard use/repetitive use of hands			
Grasp objects/fine motor skills			
Stand			
Walk			
Squat			
Kneel			
Twist			
Bend/Stoop			
Climb ladders/stairs			
Lift			
Push/Pull			
Reaching above and below shoulders			
Operate heavy equipment			
Operate motor vehicle			
Use or operate radio equipment			
Limitation on the number of consecutive hours worked			
Exposure to heat or cold			
Vision			
Hearing			
Mental/Emotional functions			
Use of wheelchair, motorized scooter, crutches, or cane			

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Other			

If the impairment is episodic and/or in remission, please specify.

_____
_____
_____
_____
_____
_____

QUESTIONS REGARDING THE ACCOMMODATION

Taking into consideration the nature, severity, and the duration of the impairment as well as the limitations imposed by the impairment, **what specific accommodation(s), if any, would you recommend for this employee/applicant/volunteer?**

_____
_____
_____
_____
_____
_____
_____

What, if any, auxiliary aid/or services may assist the employee/applicant/volunteer in effectively performing the essential functions of the position (e.g., readers, sing language interpreters, aural assistive devices, etc.)?

_____
_____
_____

Please use this space to provide any other information you feel might assist us in evaluating the employee/applicant/volunteer's request for accommodation.

_____
_____
_____
_____

By signing below, I attest that the information provided in this document is true and accurate to the best of my knowledge. I understand that providing false or inaccurate information in this context is a crime punishable under state and municipal law.

Medical Provider Name(print):	Date:
Medical Provider Signature:	Telephone:

Please attach a business card here: