

**MEDICAL QUESTIONNAIRE**  
**For Accommodation Request for Pregnancy, Childbirth, and Related Conditions**

This form is to be completed by the medical provider of a City of Chicago employee, job applicant, or volunteer who is seeking an accommodation for pregnancy, childbirth, or related conditions.

Please answer the questions below, providing as much detail as possible. **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:

Email:

Cell Phone or Work Phone:

Home Mailing Address:

Department:

Job Title:

QUESTIONS TO DOCUMENT THE REASON FOR THE REQUEST

1. Is the employee/applicant/volunteer pregnant?

Yes

No

2. Is the employee/applicant/volunteer recovering from childbirth?

Yes

No

3. Please describe the reasonable accommodations or modifications which you believe are medically advisable based upon the pregnancy, childbirth, or related common or medical condition of the employee/applicant/volunteer.

4. Is the reasonable accommodation or modification necessary because of a common or medical condition related to pregnancy or childbirth?

Yes

No

5. Please explain why the accommodation is necessary:

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6. What is the date that the requested accommodation became or will become medically advisable?

7. What is the probable duration of the need 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:**