SONOMA STATE UNIVERSITY | PAYROLL & BENEFITS

Request for Reasonable Accommodation
Health Care Provider Medical Questionnaire

To: Employee's Treating Health Care Provider
From: ADA Specialist at Sonoma State University
Via: **Patient's Name:** _____
Re: Patient's Request for Workplace Reasonable Accommodation Medical Questionnaire

Health Care Provider Name: _____ License Number: _____

Health Care Provider Phone Number: _____ Date of Examination: _____

Dear Treating Health Care Provider,

Your patient is in the process of requesting reasonable accommodations from Sonoma State University to assist them to perform the essential functions of their position fully and safely. In compliance with the requirements of Title I of the Americans with Disabilities Act (ADA) and the Fair Employment and Housing Act (FEHA), your assistance is requested to provide information in support of this request.

We respectfully request you complete the attached medical questionnaire. As part of your evaluation of the questions below, please ensure that your patient has provided you with a copy of their job description. We are only seeking a listing of work restrictions, functional limitations and their duration, if any. Please do not provide any information pertaining to a medical condition, diagnosis, or treatment.

Please either submit the completed questionnaire to Sonoma State University's ADA Specialist by fax at (707) 664-4049 or provide it to your patient who will give it to us.

Thank you for your assistance in this matter.

Sincerely,

ADA Specialist
Sonoma State University
(707) 664-2979 phone
(707) 664-4049 fax
HRAccommodations@sonoma.edu

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On behalf of my patient, based on my review of the current job description, I can provide the following clarification on their work restrictions:

(Check boxes and insert text as appropriate)

1. Does your patient have a physical or mental impairment that limits their ability to engage in a major life activity, such as the ability to work, care for themself, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities?
   ☐ NO, my patient does not have a physical or mental impairment that limits their ability to engage in a major life activity.
   ☐ YES, my patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits their ability to engage in a major life activity.

2. If the answer to question 1 is YES, does the impairment currently affect your patient's ability to perform the essential functions in the job description provided?
   ☐ NO, my patient's impairment does not limit their ability to perform any of the essential functions of their position.
   ☐ YES, my patient's impairment does affect their ability to perform **one or more** of the essential functions of their position.

   Note: If you answered NO to either question #1 or question #2, you can skip the rest of the questionnaire and sign and date the last page.

3. If you answered YES to questions 1 and 2, what work restrictions or functional limitations does your patient's disability or medical condition produce that are in need of accommodation? Please be as specific as possible (e.g. if providing a restriction to standing, how many minutes can the subject stand before they would need to sit for X minutes). List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them. **Any recommended accommodation must be supported with clear work restrictions to make the accommodation medically necessary.**

   a. **List all physical activity restrictions (circling options and inserting text as appropriate):**

   ☐ No lifting/carrying of _____ pounds or more
   ☐ No pushing/pulling of _____ pounds of force or more
   ☐ No bending at ☐ waist ☐ neck ☐ other: _____ for more than _____ times in a row or _____ times per day
   ☐ No stooping more than _____ times in a row or _____ times per day
   ☐ No weightbearing (standing/walking) for more than _____ minutes at one time or _____ hours per 8-hour day
   ☐ No kneeling ☐ right knee ☐ left knee ☐ both knees more than _____ seconds at one time or _____ times in a row or _____ times per 8-hour day
   ☐ No sitting for more than _____ minutes at one time and _____ minutes per 8-hour day
   ☐ No at (or above) shoulder level reaching more than _____ seconds / minutes (circle one) at one time or _____ seconds / minutes (circle one) per 8-hour day
   ☐ No running ☐ No jumping ☐ No climbing ladders ☐ No balancing above ground

☐ Other functional limitations (please be as specific as possible):

_____

_____

_____

_____

_____

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b. **DURATION OF RESTRICTIONS:**

☐ Restrictions are **TEMPORARY through _____ (date)**
☐ Restrictions are **PERMANENT**

4. **Additional Restrictions / Accommodation Suggestions:** Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee. **Please do not list any information pertaining to medical condition or diagnosis.**

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_____ _____

Treating Health Care Provider's Signature Date