SONOMA STATE UNIVERSITY | PAYROLL & BENEFITS

ADA Supplemental Medical Questionnaire Request
Height Adjustable Workstations

RE: Disability Interactive Process

Dear Treating Physician,

Sonoma State University is requesting your assistance in obtaining information needed to explore reasonable accommodations for your patient in compliance with the requirements of Title I of the Americans with Disabilities Act (ADA), the Fair Employment and Housing Act (FEHA), and consistent with the organizational goals of Sonoma State University to assist disabled employees to remain at work with reasonable accommodations.

Sonoma State University engages with employees to discuss reasonable accommodations that can be implemented to support them to fully and safely perform the essential functions of their position. As part of this process, we would appreciate your assistance to help us ensure that we have a full and correct understanding of any and all work restrictions / functional limitations or leave needs that may be in need of accommodation to support your patient.

We respectfully request you complete the attached Medical Questionnaire Form. Please note as part of this process, 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.

Thank you for your assistance in this matter.

Sincerely,

Tiffany Perry
Workers' Compensation, ADA, and Leave Specialist

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ADA Supplemental Medical Questionnaire Request
Height Adjustable Workstations

Date of Examination: _____

Employee Name: _____

SUPPLEMENTAL MEDICAL QUESTIONNAIRE

1. Does your patient have a physical and/or mental impairment that limits the 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 of their job?

   ☐ NO, my patient's impairment does not limit their ability to perform all 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.

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.**

   a. **List all physical activity restrictions:**

   ☐ NO repetitive lifting/carrying of _____lbs. or more
   ☐ NO lifting/carrying of _____lbs. or more
   ☐ NO repetitive pushing/pulling of _____lbs. or more
   ☐ NO pushing/pulling of _____ lbs. or more
   ☐ NO at (or above) shoulder level reaching > ____ sec./min.
   ☐ NO repetitive keyboarding in excess of ____min. per hour
   ☐ NO prolonged walking in excess of ____minutes
   ☐ Other (please be specific)

   ☐ NO repetitive bending/stooping > ____ times/row
   ☐ NO repetitive squatting/kneeling > ____ times/row
   ☐ NO prolonged standing in excess of ____ min.
   ☐ NO prolonged sitting in excess of ____ min.
   ☐ Must alternate sitting/standing every _____ min.
   ☐ NO running / jumping / climbing (circle)

   b. **ADDITIONAL CLARIFICATION/RESTRICTIONS:** _____

   _____

   _____

_____

_____

_____

c. **DURATION OF RESTRICTIONS:** Please confirm the duration of restrictions by checking the appropriate box below:

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

4. 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 provide any information pertaining to a medical condition, diagnosis, or treatment.**

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Treating Physician's Signature Date

_____ _____
Printed Name License Number

PLEASE RETURN A COPY OF THIS FORM TO:
Fax (707) 664-4049 or hraccommodations@sonoma.edu