Delgado COMMUNITY COLLEGE

REASONABLE ACCOMMODATION QUESTIONNAIRE

Employee Name: Date:

Medical Release:

I authorize the release of any medical information necessary to process the accommodation request.

Signature of Employee: Date:

Please answer the following as it relates to the employee's request for an accommodation.

1. When was your most recent evaluation of the employee?

2. Does the employee have a physical or mental impairment?
   Yes ☐ No ☐ If yes, is the impairment long-term or permanent?
   Yes ☐ No ☐ If no, how long will the impairment likely last?

3. Does the impairment affect a major life activity? Yes ☐ No ☐
   If yes, what major life activity (s) is/are affected (check all applicable boxes below)?

- *Caring for Self*
- *Breathing*
- *Thinking*
- *Learning*
- *Reproduction*
- *Interacting with Others*
- *Working*
- *Toileting*
- *Sitting*
- *Other: (describe)*
- *Performing Manual Tasks*
- *Walking*
- *Hearing*
- *Lifting*
- *Standing*
- *Seeing*
- *Sleeping*
- *Reaching*
- *Speaking*
- *Concentrating*

4. Is the employee limited in one or more of the major life activities checked above? Yes ☐ No ☐

   If yes, please describe the limitations.

5. Employee currently works in the position of _____. Please review the attached job description for this position and identify any job function you believe Employee is unable to perform as a result of the condition(s) for which you are providing treatment.

6. How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

7. What accommodations, if any, may be made to Employee's job functions to enable Employee to perform the job functions listed in response to question #5 above without endangering Employee's health or safety or the health or safety of others in the workplace?

8. Are you aware of any medication Employee is taking that would limit Employee from performing the essential job functions described in the attached job description? If so, please describe the limitations and whether any accommodation would ameliorate the limitations.

9. You stated in your note dated, that Employee may return to work on.

10. Is that return date reasonably definite?

- What is the likelihood you will require Employee to be off work for additional time?

11. Are there any alternatives to time off from work that would enable Employee to perform his/her job functions now or sooner than the additional time off you have prescribed? If so, please recommend those alternatives.

12. Is there anything else we should know that would be helpful for us to determine appropriate accommodations for Employee?

_____ _____

Signature of Health Care Provider Date

_____ _____

Health Care Provider's Name Telephone

_____ _____

Address Fax

_____

City State Zip