ADA MEDICAL QUESTIONNAIRE
Howard County Public School System

Employee Name:_____

E-Number:_____

Medical Condition: _____

The person listed above is an employee of the Howard County Public School System (HCPSS). S/he has requested an accommodation for a medical condition, under the Americans with Disabilities Act (ADA) and has identified you as his/her health care provider. The employee claims that the condition requires an accommodation under the ADA to enable him/her to perform the essential functions of his/her job.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by and individual or family member receiving assistive reproductive services. (75 Fed. Reg. 68934)

To assist the HCPSS in evaluating this request for accommodation, please answer the following questions. Please provide specific and detailed answers to these questions, ***using additional sheets where necessary****. To assist you in completing this medical questionnaire, some questions contain narratives and definitions. Kindly review the narratives and/or definitions before answering the question.* ***HCPSS*** *will use the information to evaluate the employee's request for accommodation in accordance with the ADA. The information you provide will be confidential and used only to evaluate the employee's request for accommodation. Please return the completed form within 15 days via Fax to (443) 973-5598 or E-mail to ADA_Coordinator@hcpss.org.*

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1. Have you examined the employee for the above-stated condition?

   Yes ☐ No ☐

   Date of examination(s): _____

2. Does the employee have a "physical or mental impairment?"

   Yes ☐ No ☐

   In answering this question, you should understand that the ADA defines a physical or mental impairment as (1) any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

3. If you answered "yes" to question 2, please identify the specific physical or mental impairment (diagnosis):

_____
_____
_____
_____
_____

4. Does the above-identified impairment substantially limit a major life activity of the employee?

Yes ☐ No ☐

In answering this question you should understand that the phrase "substantially limit" means (i) unable to perform a major life activity that the average person in the general population can perform; or (ii) significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner or duration under which the average person in the general population can perform that same major life activity.

You should also understand that the phrase "major life activities" includes, but is not necessarily limited to, functions such as caring for oneself, performing manual tasks, sitting, standing, lifting, reaching, walking, seeing, hearing, speaking, breathing, learning and working. For some people, mental impairment restrict major life activities such as learning, thinking, concentrating, interacting with others, caring for oneself, speaking, performing manual tasks, or working. Sleeping is also a major life activity that may be limited by mental impairment.

5. If you answered "yes" to question 4, please describe what major life activity(ies) is substantially limited?

_____
_____
_____

6. Please describe how and to what extent the impairment substantially limits the above-described major life activity(ies).

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_____
_____
_____

7. What is your prognosis for whether, and in what manner, the impairment will continue to limit or not limit the above-described major life activity(ies)?

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_____
_____
_____
_____

8. Is the impairment permanent?

Yes ☐ No ☐

9. If the impairment is not permanent, what is the expected duration of the impairment?

_____
_____
_____
_____
_____

10. In what specific way(s) if any, and to what extent, does the impairment affect his/her ability to perform the essential functions of his/her job? (See attached job description).

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_____
_____
_____
_____
_____
_____

11. Are there any corrective devices (such as prosthesis, eyeglasses or hearing aids) or other measures (such as medication or therapy) available to treat the above-described medical condition? These are also known as "mitigating measures"

Yes ☐ No ☐

12. If you answered "yes" to question 11, please identify the corrective devices or other measures?

_____
_____
_____
_____
_____

13. Have any corrective devices or other measures been prescribed or recommended to the employee for the above-described medical condition?

Yes ☐ No ☐

14. If you answered "yes" to question 13, identify the prescribed or recommended corrective devices or other measures?

_____
_____
_____
_____

15. Does the employee utilize the prescribed or recommended corrective devices or other measures?

Yes ☐ No ☐

16. If you answered "yes" to question 15, what positive or negative effects do the corrective devices or other measures have on the employee's ability to perform the essential functions of his/her job? (ATTACHED)

_____
_____
_____
_____
_____

17. When using the corrective devices or other measures, which of the essential job functions is the employee able to perform now?

_____
_____
_____
_____

18. When using the corrective devices or other measures, which of the essential job functions is the employee unable to perform?

_____
_____
_____
_____

19. Please provide any other medical information or documentation that you believe will assist **HCPSS** in evaluating the nature, severity and duration of the employee's impairment; the activity or activities the impairment limits; and the extent to which the impairment limits his/her ability to perform the activity or activities.

_____
_____
_____
_____
_____

20. If there continues to be limitations on the employee's ability to perform essential functions of his/her job, even after mitigation, do you believe an accommodation is necessary to enable his/her to perform the essential functions of his/her job?

Yes☐ No☐

21. If you answered "yes" to question 20, what recommendations do you have as to accommodation(s) that would enable the employee to perform fully the essential functions of his/her job?

_____
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_____

22. Please describe your medical expertise as it relates to your ability to give the above-described opinions.

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_____
_____

Thank you for taking the time to complete this ADA Medical Questionnaire. **HCPSS** will use the information you have provided to evaluate the employee's request for accommodation in accordance with the ADA.

Physician's Signature	**Date**
Physician's Name (Printed or Typewritten)	**Telephone Number**
Physician's Business Address	**Fax Number**