University of Idaho
Human Resources

Health Care Professional's Inquiry Form

(To be completed by health care provider)

Instructions to the Health Care Provider

As part of the reasonable accommodation process, the University of Idaho requires documentation that an employee or applicant has a qualifying disability. The employee/applicant named below is requesting an accommodation. ***Please complete the following information and return to Human Resources at the address and/or fax provided.***

The information you provide assists the University of Idaho in determining appropriate services and/or accommodations for this employee/applicant. A person has a qualifying disability under the Americans With Disabilities Act if he or she has:

- A physical or mental impairment that substantially limits one or more major life activities,
- a record of such an impairment
- alternatively, if he or she is regarded as having such an impairment.

To assist you in providing this documentation, the description of the position held by the employee, or for which the applicant is applying, is provided. The University of Idaho encourages you to be thorough in your evaluation as you complete the sections below. Attach additional information as needed.

NOTE: Failure to complete this form in a timely manner may lead to delay or denial of the requested accommodation.

Complete Sections 1, 2, 3 and 8 (required). Also, complete any other applicable sections below.

□ **1. Questions to Assist in Determination of Disability (required)**
□ **2. Ability to Work (required)**
□ **3. Questions to Assist in Determination of Effective Accommodation (required)**
□ 4. Additional comments or information (if needed))
□ 5. Physical Capacities Evaluation (If needed for the accommodation/essential job functions of this request)
□ 6. Cognitive/Psychological Capacities Evaluation (if applicable)
□ 7. Other Restrictions and Effects of Medication (if applicable)
□ 8. **Signature and Credentials of Health Care Provider (required)**

Using the spaces provided or by attaching a letter, please describe your diagnosis or diagnoses of each **job-related** impairment. For each diagnosed impairment, please identify each major life activity substantially limited by the impairment and the nature of the substantial limitation. (For example, if the individual is limited in her ability to walk, please specify the specific nature of the limitation, such as unable to walk on uneven surfaces, or able to climb maximum of two flights of stairs.)

Please suggest accommodations (if any) relating to each of your diagnoses with reference, if possible, to each affected essential function of the attached job description/position description.

Authorization from Individual seeking a Reasonable Accommodation in Employment

I hereby authorize you and any doctor, medical provider, or medical institution having information concerning my ability to perform the essential functions of the attached job description/position description to release this information to the University of Idaho Human Resources, or its designated representative.

Employee/Applicant Signature:	***Date:***

NOTE TO EMPLOYEE/APPLICANT: Do NOT return this form to your department or supervisor.

Reasonable Accommodation in Employment

University of Idaho
Human Resources

To be completed by Health Care Professional:

EMPLOYEE/APPLICANT/PATIENT NAME (Last, first, middle initial)	Vandal ID # (If applicable)

1. Questions to help assist in the determination of a disability (required). Please review employee job description/position description for reference when completing. (Attach additional sheet if needed)

Does the employee have a physical or mental impairment?	Yes* ☐ No ☐
*If yes, what is the impairment? Please provide information on medical diagnosis and date of the most recent evaluation)	
Is the impairment long-term? *If Yes, Likely Duration: From: _____ to: _____	Yes* ☐ No ☐
Is the impairment short-term? *If Yes, Likely Duration: From: _____ to: _____	Yes* ☐ No ☐
Is the impairment permanent?	Yes ☐ No ☐
Does the impairment substantially limit a major life activity?	Yes* ☐ No ☐

*If yes, what major life activity(s) is/are affected? Check all that apply and briefly describe:

☐ Caring For Self	☐ Breathing	☐ Working	☐ Walking	☐ Standing
☐ Hearing	☐ Seeing	☐ Reaching	☐ Thinking	☐ Toileting
☐ Speaking	☐ Learning	☐ Sitting	☐ Lifting	☐ Sleeping
☐ Concentrating	☐ Reproduction	☐ Interacting with Others		☐ Perform Manual Tasks

☐ Other (describe):

Is the employee substantially limited in one or more of these major life activities? Yes ☐ No ☐

2. Ability to Work (required). Please review employee job description/position description for reference when completing. (Attach additional sheet if needed)

What are the limitation(s) that interfere with employee's ability to perform job duties?

EMPLOYEE/APPLICANT/PATIENT NAME (Last, first, middle initial)	Vandal ID # (If applicable)

What job duties is the employee having trouble performing because of the impairment or limitation(s)?

How do the employee's limitation(s) interfere with his/her ability to perform the job duties?

3. Questions to assist in effective accommodation determination (required). Please review employee job description/position description for reference when completing. (Attach additional sheet if needed)

A. Do you have any suggestions for possible accommodations to assist with completing the job duties? If so, what are they?

B. If recommending a **temporary or permanent job modification**, e.g., work schedule, lifting, graduated return to work, etc. Please specify:

Is this modification medically necessary? ☐Yes ☐No	Duration of proposed modification: (Include mm/dd/yy)

C. If recommending a **medical leave** of absence, specify:

Medical leave is anticipated to extend:	From (mm/dd/yy)	To (mm/dd/yy)	Date employee/patient will be able to return to work (mm/dd/yy):

How would your suggestions improve the employee's ability to perform job duties?

4. Comments or additional information in support of request.

EMPLOYEE/APPLICANT/PATIENT NAME (Last, first, middle initial)	Vandal ID # (If applicable)

5. Physical Capacities Evaluation Please review employee job description/position description for reference and complete this section if appropriate to the accommodation/essential job duties.

Important: Complete the following items based on your clinical evaluation of the patient and other testing results. Enter "N/A" for any evaluation items that you do not believe you can answer.

Not applicable for this accommodation (no evaluation provided) ☐
No physical restrictions needed ☐

A. IN ONE SHIFT, PATIENT CAN: (Mark or check employee/patient's full capacity for each activity)

	Never	Rarely (Once a week or less)	Occasionally (0-2.5 hrs./day)	Frequently (2.5-5.5 hrs./day)	Continuously (5.5 hrs. + / day)
Sit					
Stand (in place)					
Walk					

B. PATIENT CAN LIFT: (Mark or check employee/patient's full capacity for each activity)

	Never	Rarely (Once a week or less)	Occasionally (0-2.5 hrs./day)	Frequently (2.5-5.5 hrs./day)	Continuously (5.5 hrs. + / day)
0-10 lbs					
11 – 25 lbs					
26 – 50 lbs					
51 – 100 lbs					

C. PATIENT CAN CARRY: (Mark or check employee/patient's full capacity for each activity)

	Never	Rarely (Once a week or less)	Occasionally (0-2.5 hrs./day)	Frequently (2.5-5.5 hrs./day)	Continuously (5.5 hrs. + / day)
0-10 lbs					
11 – 25 lbs					
26 – 50 lbs					
51 – 100 lbs					

D. PATIENT CAN PUSH/PULL: (Mark or check employee/patient's full capacity for each activity)

	Never	Rarely (Once a week or less)	Occasionally (0-2.5 hrs./day)	Frequently (2.5-5.5 hrs./day)	Continuously (5.5 hrs. + / day)
0-10 lbs					
11 – 25 lbs					
26 – 50 lbs					
51 – 100 lbs					

E. PATIENT IS ABLE TO: (Mark or check employee/patient's full capacity for each activity)

	Never	Rarely (Once a week or less)	Occasionally (0-2.5 hrs./day)	Frequently (2.5-5.5 hrs./day)	Continuously (5.5 hrs. + / day)
Bend					
Squat					
Kneel					
Reach out					
Reach above shoulder level					
Turn/Twist Upper Body					

EMPLOYEE/APPLICANT/PATIENT NAME (Last, first, middle initial)	Vandal ID # (If applicable)

F. PATIENT IS ABLE TO: (Mark or check employee/patient's full capacity for each activity)

	Never	Rarely (Once a week or less)	Occasionally (0-2.5 hrs./day)	Frequently (2.5-5.5 hrs./day)	Continuously (5.5 hrs. + / day)
Operate heavy machinery					
Drive a stick-shift vehicle					
Work with or near moving machinery					

G. OTHER: Please describe:

6. Cognitive/Psychological Capabilities Evaluation. Please review employee job description/position description for reference when completing. (Attach additional sheet if needed)

Not applicable for this accommodation (no evaluation provided) ☐
No Cognitive/Psychological limitations ☐

Statement of Psychological / Cognitive Diagnosis(es) (Include or attach appropriate DSM or ICD)

How often is patient receiving treatment from you and /or another health care provider for this condition?

Functional limitation:

Clarify or add any additional information. ☐Yes ☐No

EMPLOYEE/APPLICANT/PATIENT NAME (Last, first, middle initial)	Vandal ID # (If applicable)

7. Other Restrictions and Effects of Medication (Provide if appropriate to accommodation/essential job duties)

Other Restrictions not Described in other sections of this form: (Describe as needed)

Are these restrictions medically necessary? ☐Yes ☐No	Anticipated duration of these restrictions: From mm/dd/yy _____ To mm/dd/yy_____

Medication: Is patient currently prescribed medication that may impair cognitive function, ability to operate machinery, stay alert, be punctual, or maintain regular attendance? ☐Yes ☐No

(If yes, explain below. Include the anticipated duration that this (or similar) medication will be prescribed for patient.)

8. Signature and Credentials of Health Care Provider (required)

I certify that the information provided in this form (Sections 1, 2 and 3, and as applicable, 4, 5 6 and 7) is true and correct to the best of my knowledge.

Health Care Provider Name (Print or type):	Title and Specialty:

Health Care Provider Address:

City:	State:	Zip Code:	Telephone/Fax:

Board Certified: Yes* ☐ No ☐	*If Certified indicate area:
	License # and Date of Expiration:
Health Care Provider Signature:	**Date:**

*The above signature indicates, a review of the essential functions of the job description/position description provided by the employee/applicant has been completed and considered in this recommendation.