CITY OF CHICAGO
MEDICAL QUESTIONNAIRE
FOR REASONABLE ACCOMMODATION REQUEST

This form is to be completed by the medical provider of a City of Chicago employee, job applicant, or volunteer. Please be as detailed as possible in your answers. **Please fax the completed form to the City of Chicago Department of Human Resources at (312) 744-9710.** You may attach additional paper if more room is needed to fully answer a question. If you have any questions, please call the Disability Officer at (312) 744-4969.

The information we are seeking relates only to any condition your patient may have that affects his/her ability to perform their essential job functions or access job benefits. Please note that 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.

YOUR PATIENT -- OUR EMPLOYEE/APPLICANT/VOLUNTEER	
Name:	
Job Title or Position Applying To:	Date of Birth:
Home Phone:	Department:

QUESTIONS TO DOCUMENT THE REASON FOR THE REQUEST

Does the employee/applicant/volunteer have a physical or mental impairment? If so, please **identify and describe** the physical or mental impairment. An "impairment" could include an injury to the human body.

Based on reasonable medical certainty, is the impairment permanent?

______Yes ______No

If "No", please state the length of anticipated duration and/or prognosis.

Is the impairment episodic or chronic?

If episodic, please describe the expected frequency and duration of symptoms.

For Disability Office Use Only

File Number: _________________________

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Does the physical or mental impairment, when active, substantially limit a major life activity or a major bodily function of the employee/applicant/volunteer?

______Yes ______No

If yes, please identify all major life activities or bodily functions that are limited by using the check boxes below:

Major Life Activities: Please check all that apply. Use the space below to note any affected major life activities not listed.

_____Eating
_____Standing
_____Walking
_____Breathing
_____Seeing
_____Pushing
_____Reaching
_____Lifting
_____Bending
_____Concentrating
_____Learning
_____Speaking
_____Hearing
_____Sitting

Other____

Major Bodily Functions: Please check all that apply. Use the space below to note any affected major bodily functions not listed.

_____Immune system
_____Bowel
_____Bladder
_____Neurological
_____Respiratory
_____Circulatory
_____Lymphatic
_____Musculoskeletal
_____Special Sense Organs and Skin
_____Normal Cell Growth
_____Digestive
_____Genitourinary
_____Cardiovascular
_____Endocrine
_____Hemic
_____Reproductive Functions

Other:____

Does the impairment interfere with the employee/applicant/volunteer's ability to perform his/her job?

_____Yes _____No

If yes, please indicate on the following page which job functions are restricted and how the restriction interferes with the ability to perform the job. **This form may be returned and/or the employee's request may be denied if the information you provide is not specific enough to allow us to understand the nature and extent of the employee's restrictions.**

Please contact the Disability Officer if you would like a copy of the employee's job description in order to prepare your response.

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Job Function or Work Conditions	**Is There a Restriction? Yes or No**	**Explain Limitation**	**Specify Extent of Limitation**
Example: *Exposure to heat or cold*	*Yes*	*Cannot be exposed to extremely cold temperatures*	*Max exposure 15 minutes when the temperature is less than 20 degrees Fahrenheit.*
Repetitive use of hands or fingers			
Grasp objects/fine motor skills			
Sit			
Stand			
Walk			
Squat or kneel			
Twist			
Bend or stoop			
Climb ladders or stairs			
Lift			
Push or pull			
Reach above and below shoulders			
Use power tools			
Operate heavy equipment			
Operate motor vehicles			
Number of consecutive hours worked			
Time of day worked			
Exposure to heat or cold			
See			
Hear			
Speak			
Comprehend/process information			
Regulate mood and emotions			
Other (please specify):			

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QUESTIONS REGARDING THE ACCOMMODATION

Taking into consideration the nature, severity, and the duration of the impairment as well as the limitations imposed by the impairment, **what specific accommodation(s), if any, would you recommend for the employee/applicant/volunteer**?

What, if any, auxiliary aids/or services may assist the employee/volunteer in effectively performing the essential functions of the position (e.g. readers, sign language interpreters, aural assistive devices, etc.)?

Please use this space to provide any other information you feel might assist us in evaluating the employee/applicant/volunteer's request for accommodation.

By signing below, I attest that the information provided in this document is true and accurate to the best of my knowledge. I understand that providing false or inaccurate information in this context is a crime punishable under state and municipal law.

Medical Provider Name (print):	Date:
Business Address:	Type of Practice/Specialty:
Medical Provider Signature:	Telephone: