Human Resource Department
Centenary College of Louisiana
2911 Centenary boulevard
Shreveport, LA 71104
Phone: 318-869-5191
hr@centenary.edu
www.centenary.edu

MEDICAL INQUIRY FORM IN RESPONSE TO ACCOMMODATION REQUEST

Request for Accommodation Based on Disability

This form must be completed in order for a qualified disabled employee of the College to request reasonable accommodation to perform the essential functions of their position or to enjoy privileges or benefits of employment equivalent to non-disabled employees. Your request for reasonable accommodation will be reviewed by Human Resources in conjunction with other management staff as appropriate. You will be notified of the College's decision in a reasonable time after this form is received in the Human Resources Office.

Employee Information

Date:______________________________________ Employee ID#______________________________________

Name:____ Title:_______________________________________

Home Address:____

I do hereby authorize Centenary College of Louisiana to communicate both verbally and in writing, if necessary, with the appropriate health care or rehabilitation professionals with regard to the resolution of my request for a disability accommodation. My signature indicates that I am aware of the nature of the information being disclosed and with whom it will be shared.

Your Signature:____ Date:__________________________

To Be Completed by Physician or Appropriate Medical Professional

Name of certifying professional (please print)____

Title:____ Certification or License#:_________________________________

Telephone:____

Business Address:____

City/State/Zip:____

Signature:____ Date:__________________________________

Content of this request is confidential and will not be shared by any staff member except to consider the implementation of the disability accommodation.

The medical information below is requested by the Centenary college of Louisiana so that the College may evaluate a request for reasonable accommodation made by the above employee/applicant under the Americans with Disabilities Act ("ADA") and related state law. The College seeks information to help it determine whether the employee/applicant has a "covered disability" and the nature and extent of the employee/applicant's "functional limitations." Under the ADA, a "disability" is defined as "a physical or mental impairment which limits one or more major life activities.” Examples of major life activities include performing manual tasks, walking, seeing, hearing, speaking, learning, and working.

Questions to help determine whether an employee has a disability

For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability.

QUESTION	ANSWER
Does the employee have a physical or mental impairment?	☐ Yes ☐ No
If yes, what is the impairment?	
Is the impairment long-term or permanent?	☐ Yes ☐ No
If *not* permanent, how long will the impairment last?	

Please answer the following questions based on the limitations the employee has when his/her condition is in an active state and the limitations the employee would have if no mitigating measures were used. Mitigating measures include medication, medical supplies, equipment, hearing aids, mobility devices, use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

QUESTION	ANSWER
Does the impairment substantially limit a major life activity? *Note: Does not need to significantly or severely restrict to meet this standard.*	☐ Yes ☐ No
If yes, what major life activity(s) is/are affected?	☐ Caring for self ☐ Interacting with others ☐ Performing manual tasks ☐ Breathing ☐ Working ☐ Walking ☐ Standing ☐ Reaching ☐ Thinking ☐ Toileting ☐ Hearing ☐ Seeing ☐ Speaking ☐ Learning ☐ Sitting ☐ Lifting ☐ Sleeping ☐ Concentrating ☐ Reproduction ☐ Other:_____________________________
Does the impairment substantially limit the operation of a major bodily function? *Note: Does not need to significantly or severely restrict to meet this standard.*	☐ Yes ☐ No
If yes, what bodily function(s) is/are affected?	☐ Immune ☐ Special sense organs & skin ☐ Reproductive ☐ Bladder ☐ Respiratory ☐ Hemic ☐ Endocrine ☐ Bowel ☐ Brain ☐ Cardiovascular ☐ Circulatory ☐ Digestive ☐ Neurological ☐ Special Sense ☐ Normal cell growth ☐ Lymphatic ☐ Musculoskeletal ☐ Genitourinary ☐ Other:_____________________________
Please provide specific restrictions for each box checked above.	

Diversity and Inclusion are a part of Centenary Colleges heritage. We are a recognized employer and educator valuing EEO, Protected Veterans, and Individuals with Disabilities.

Questions to help determine whether an accommodation is needed

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability.

QUESTION	ANSWER
What limitation(s) is/are interfering with job performance?	
What job function(s) is/are the employee having trouble performing because of the limitation(s)?	
How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?	
Do you have any suggestions regarding possible accommodations to improve job performance?	
How would your suggestions improve the employee's job performance?	

Please include below specific workplace accommodations or workplace aids that are necessary to enable the employee to perform the essential job functions and to the extent possible the duration of the accommodation including start and end dates, and if anticipates to be permanent.

Comments

Signature of Physician/Medical

Professional____

Date____

If required, please use additional sheets for any of the information requesed above.

Return this form by mail or email to:
Centenary College of Louisiana
2911 Centenary Boulevard
Shreveport, LA 71104
Fax: 318-869-5281

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' as defined by GINA, 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 an individual or family member receiving assistive reproductive services

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RETURN TO WORK CERTIFICATION

The purpose of this form is to provide restrictions to the employer to enable the worker to return to alternate or modified work as soon as possible, to identify suitable work that is both productive and safe, and to provide work assignments that honor the outlined restrictions. If the empoyer is uinable to offer work that is approppriate ti the outlined restrictions the worker will be off work.

SECTION I – To be completed by the EMPLOYER

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

EMPLOYEE'S DEPARTMENT

DEPARTMENT CONTACT

PHONE	FAX	E-MAIL

SECTION II – To be completed by HEALTH CARE PROVIDER

NAME OF HEALTH CARE PROVIDER

ADDRESS	PLACE ADDRESS STAMP HERE:

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE

OR TO THE DEPARMENT CONTACT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE

Important: Please limit your answers below to the serious health condition for which the Employee has been on leave.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): 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,' as defined by GINA, 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 an individual or family member receiving assistive reproductive services.

1. Is the employee now able to perform those essential functions of his or her job that she could not previously perform because of the serious health condition for which the employee has been on leave?

   ☐ **NO**. Employee is currently not able to work. I anticipate employee will be able to return to work on:

   ☐ YES. Employee is able to return to **REGULAR WORK DUTIES** on:

   YES. Employee is able to return to **WORK WITH RESTRICTIONS** on:

3. If the Employee is released to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions:

4. The foregoing restrictions are:

   ☐ Permanent

   ☐ Temporary, until: ____________________ *[indicate date]*

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER	DATE