First ADAAA Medical Questionnaire Pertaining to [Employee's Name]

(Employee Name) is employed as a (Job Title) with the Department of Public Safety, Office of Juvenile Justice. Attached are his/her Position Description and the Physical Requirements and Conditions of (Employee Name)'s (Job Title) position.

The Office where (Employee Name) works (Insert general description of work performed).

The essential job duties for (Employee Name) serving in the (Job Title) position in the Office of Juvenile Justice include, but are not limited to, the following: (Insert specific job duties for the employee requesting an accommodation).

(Employee Name)'s job duties as a (Job Title) are generally performed (Insert specific physical requirements).

The facts which compelled this inquiry are as follows:

During the week of (month/date/year), (Employee Name) advised his/her chain of command that he/she had been diagnosed with (diagnosis). He/she indicated that the condition was affecting his/her ability to do his/her job.

Since (Employee Name) has set forth that he/she has medical conditions for which he/she may be unable to perform an essential function(s) of his/her job and is seeking an accommodation, the employer requires further explanation as to his/her condition and possible accommodations, if necessary and possible, to assist in the performance of his/her duties.

In view of the foregoing, please respond to the following:

1. It is has been set forth that (Employee Name) has (Name/Description of condition if known). Please confirm that (Employee Name) has been diagnosed with and currently has this condition.

   ____Yes ____No

   Explain Answer: _____
   _____
   _____
   _____
   _____
   _____

2. Does (Employee Name) currently have any other condition(s) that impacts his/her ability to perform his/her job duties? If yes, please identify the condition(s).

   ____Yes ____No

   Explain Answer:_____
   _____
   _____
   _____
   _____
   _____

3. Does this condition(s) affect a major bodily function (e.g. functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and/or reproductive functions)?

   (Insert Name of Known Condition) :____Yes ____No

   Other Condition_____: ____Yes ____No

   Explain Answer:_____
   _____
   _____
   _____
   _____
   _____

4. Does this condition(s) affect one or more of the body's multiple systems (e.g. special sense organs, neurological, musculoskeletal, respiratory, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine systems or a mental or psychological disorder)?

   (Insert Name of Known Condition):____Yes____No

   Other Condition_____: ____Yes ____No

   Explain Answer:_____
   _____
   _____
   _____
   _____
   _____

5. Does this condition(s) substantially limit a major life activity (e.g. caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and/or working)?

   (Insert Name of Known Condition):____Yes____No

   Other Condition_____: ____Yes ____No

   Explain Answer:_____
   _____
   _____
   _____
   _____
   _____

6. What is the nature of this condition(s)—permanent, temporary, episodic, etc.? Please provide an answer for each condition.
   Explain Answer:_____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

7. Does this condition(s) prevent _(Employee Name)_____from performing any of the essential functions of his/her job as detailed above and/or as provided in the attached position description and physical requirements and condition?

   (Insert Name of Known Condition):____Yes____No

   Other Condition_____: ____Yes ____No

   Explain Answer:_____
   _____
   _____
   _____
   _____
   _____

8. If response to 7 above is yes, describe the essential function(s) affected by the condition(s) and how it is affected.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

9. Please provide any suggested accommodations, if necessary, which would allow (Employee Name) to perform his/her job duties? Explain answer, including how this accommodation would allow (Employee Name) to perform his/her job duties and lessen the impact of the condition:

_____
_____
_____
_____
_____
_____
_____
_____
_____

10. Can medication or aids mitigate the effects of this condition(s)?

____Yes ___No

Explain Answer:_____
_____
_____
_____
_____
_____

11. Please include any additional, relevant information:

_____
_____
_____
_____
_____
_____
_____
_____

Date: _____ _____

Signature of Doctor

Phone No:_____ _____

Name of Doctor (Print)

_____ _____

Type of Practice (Print)

_____

Address of Doctor (Print)