

Request for Medical Information

To be completed by an appropriate Health Care Practitioner or Rehabilitation Counselor and returned to the U.S. Census Bureau - Disability and Diversity Program Office (DDPO) either by interagency mail, email: hrd.accommodations@census.gov or Secure Fax: 301-763-9895. If you have any questions, please contact our office at 301-763-4060.

Name of Applicant/Employee: _____

Instructions: The person above has requested a reasonable accommodation and we require medical information to support his/her request. An accommodation is an adjustment or alteration that enables a qualified person with a disability to successfully perform the essential functions of their current position. Please attach a separate sheet if more space is needed.

A. Disability Confirmation		
For reasonable accommodation under the ADA, as amended, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or has a record of such impairment. The following questions will help confirm whether an employee has a disability:		
Does the employee have a physical or mental impairment? <i>(circle/check)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If <u>yes</u> , what is the impairment?		
Is the impairment permanent? <i>(circle/check)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If <u>not</u> permanent, how long will the impairment likely last?		
Answer the following questions based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if <u>no</u> mitigating measures were used. <i>(Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures <u>do not</u> include ordinary eyeglasses or contact lenses.)</i>		
Does the impairment substantially limit a major life activity? <i>(circle/check)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If <u>yes</u> , what major life activity(s) is/are affected? <i>(circle/check all that apply)</i>		
<input type="checkbox"/> Caring For Self	<input type="checkbox"/> Walking	<input type="checkbox"/> Hearing
<input type="checkbox"/> Interacting With Others	<input type="checkbox"/> Standing	<input type="checkbox"/> Seeing
<input type="checkbox"/> Performing Manual Tasks	<input type="checkbox"/> Reaching	<input type="checkbox"/> Speaking
<input type="checkbox"/> Breathing	<input type="checkbox"/> Thinking	<input type="checkbox"/> Learning
<input type="checkbox"/> Other (Describe):	<input type="checkbox"/> Lifting	<input type="checkbox"/> Working
	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Sitting
	<input type="checkbox"/> Concentrating	<input type="checkbox"/> Toileting
	<input type="checkbox"/> Reproduction	
Does the impairment substantially limit the operation of a major bodily function? <i>(circle/check)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If <u>yes</u> , what bodily function is affected? <i>(circle/check all that apply)</i>		
<input type="checkbox"/> Immune	<input type="checkbox"/> Hemic	<input type="checkbox"/> Circulatory
<input type="checkbox"/> Normal Cell Growth	<input type="checkbox"/> Special Sense Organs and Skin	<input type="checkbox"/> Endocrine
<input type="checkbox"/> Digestive	<input type="checkbox"/> Lymphatic	<input type="checkbox"/> Reproductive
<input type="checkbox"/> Bowel	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Bladder	<input type="checkbox"/> Brain	<input type="checkbox"/> Special Sense
<input type="checkbox"/> Other: (describe)		<input type="checkbox"/> Cardiovascular
		<input type="checkbox"/> Respiratory
		<input type="checkbox"/> Genitourinary

B. Accommodation Determination

Note: Applicant/Employee is to provide the Health Care Practitioner or Rehabilitation Counselor with a copy of their position/job description for this section.

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

What specific functional limitation(s) is interfering with job performance or work-related activities and their extent?

What job function(s) is 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)?

C. Accommodation Options

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

Please outline any suggestions you have regarding possible accommodations to improve job performance and please be specific as possible.

D. Medical Certification

Health Care or Counselor's Name: _____ Date: ____/____/____

Office Address: _____

Office Telephone Number: (____) _____ - _____ Office Email: _____

I understand that the U.S. Census Bureau Medical Review Officer (MRO) may contact me for additional information.

Signature: _____

E. Document Completion and Legibility

Sections A through D must be completed in full and be legible (readable). If not, this form will be returned for correction and it may delay processing his/her (applicant/employee) request.