CALIFORNIA STATE UNIVERSITY
LONG BEACH

Request for Reasonable Accommodation for Personal Medical Condition

Employee's Health Care Provider to Complete:

Patient Name:

MEDICAL QUESTIONNAIRE

(Check boxes and insert text as appropriate)

1. Does your patient have a medical and/or psychological impairment **as defined under the ADA/FEHA** that limits their ability to engage in a major life activity, such as the ability to work, care for themself, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities?
   ☐ NO, my patient does not have a physical or mental impairment that limits their ability to engage in a major life activity.
   ☐ YES, my patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits their ability to engage in a major life activity.

If you have answered NO to question #1, and indicated that your patient DOES NOT have a covered medical condition:

- Please skip the rest of the questionnaire and sign and date the last page.
- Note: Answering "No" to question #1 will mean that your patient is not entitled to reasonable accommodation exploration as they do not have a medical condition that limits them at work.

If you have answered YES to question #1, and indicated that your patient does have a covered medical condition that limits their ability to engage in a major life activity:

- Please complete the rest of the questionnaire as this will indicate that your patient would benefit from an exploration of reasonable accommodations, as needed and available.

2. Please check the major life activities that limits the patient's ability to perform one or more of the essential functions of their job. Please check all that apply.

☐ Bending	☐ Lifting	☐ Speaking
☐ Breathing	☐ Performing Manual Tasks	☐ Standing
☐ Caring for Oneself	☐ Reaching	☐ Thinking
☐ Concentrating	☐ Reading	☐ Walking
☐ Hearing	☐ Seeing	☐ Working
☐ Interacting with Others	☐ Sitting	
☐ Learning	☐ Sleeping	

☐ Other (Please describe): _____

Major Bodily Functions: (Please check all that apply)

☐ Bladder	☐ Endocrine	☐ Neurological
☐ Bowel	☐ Genitourinary	☐ Normal Cell Growth
☐ Brain	☐ Hemic	☐ Operation of an Organ
☐ Cardiovascular	☐ Immune	☐ Reproductive
☐ Circulatory	☐ Lymphatic	☐ Respiratory
☐ Digestive	☐ Musculoskeletal	☐ Special Sense Organs & Skins

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☐ Other (Please describe): _____

3. For each major life activity identified above, please describe how the patient is limited. Please include frequency and duration of limitation if applicable.

4. Do you consider the patient's disorder, condition, etc. to be temporary and non-chronic?
   ☐ Yes ☐ No
   (please explain)

5. Is the patient unable to perform one or more of the essential functions of his/her position as a result of the condition, disorder, etc.?

   ☐ Yes ☐ No

   a. If the answer to Question 5 is "YES", please describe the essential function(s) the patient is unable to perform.

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b. If the answer to Question 5 is "YES", how long do you anticipate that these work restrictions / functional limitations will be in place?

☐ Work Restrictions / Functional Limitations are **TEMPORARY through _____ (date)**
☐ Work Restrictions / Functional Limitations are **PERMANENT**
☐ Work Restrictions / Functional Limitations are for and **UNKNOWN** duration for the following reason(s)
(please explain why you cannot estimate the duration)

c. If the answer to Question 5 is "YES", do you know of any modifications or other accommodation that would enable the patient to perform the affected essential functions of the job?

☐ Yes ☐ No

If "YES", please describe in detail the suggested job modification(s) or other work accommodation(s) and the manner by which it would enable your patient to perform the affected essential job functions.

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6. **ADDITIONAL RESTRICTIONS / CLARIFICATIONS**: Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee. **Please do not list any information pertaining to medical condition or diagnosis.**

Health Care Provider's Original Signature	Date
Health Care Provider's Name Printed	License Number
Health Care Provider's Phone Number	Fax Number

RETURN A COPY OF THIS FORM VIA FAX OR EMAIL TO:
California State University, Long Beach / Attn.: Matt Menchaca / Fax #: 562.985.1680
OR via email at AA-FacultyLOA@csulb.edu