Americans with Disabilities Act (ADA)
Medical Information Questionnaire

Note: *This form should be accompanied by the employee's current job description.*

The purpose of this form is to assist Salt Lake County in determining whether, or to what extent, a reasonable accommodation is required for an employee to perform the essential functions of his or her job safely and effectively.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits Salt Lake County 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.

Section I: To be completed by the employee or designee

Employee Name: _____ Job Title: _____

Employee ID: _____ Department/Division: _____

Section II: To be completed your health care provider

Questions to determine whether an employee has a disability (Under the ADA an employee has a disability if he/she/they have an impairment that substantially limits one or more major life activities or bodily functions or has a record of such an impairment.

1. Does the employee have a physical or mental impairment: ☐ Yes ☐ No

   a. If yes, what is the nature of the impairment:

Answer the following question 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 no mitigating measures were used. Mitigating measures my include such things as medication, medical devices, hearing aids, mobility devices, prosthetics, etc.

2. Does the impairment substantially limit a major life activity and/or major bodily function? Yes ☐ No ☐

   a. Describe the employee's limitations when the impairment is active.

   b. If yes, what major life activities (including bodily functions) is/are affected:

Major life activities:

- ☐ Bending
- ☐ Breathing
- ☐ Caring For Self
- ☐ Concentrating
- ☐ Eating
- ☐ Other
- ☐ Hearing
- ☐ Interacting With Others
- ☐ Learning
- ☐ Lifting
- ☐ Performing Manual Tasks
- ☐ Reaching
- ☐ Reading
- ☐ Seeing
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Walking
- ☐ Working

Major bodily functions:

- ☐ Bladder
- ☐ Bowel
- ☐ Brain
- ☐ Cardiovascular
- ☐ Circulatory
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinary
- ☐ Hemic
- ☐ Immune
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Normal Cell Growth
- ☐ Operation of an Organ
- ☐ Reproductive
- ☐ Respiratory
- ☐ Special Sense Organs & Skin
- ☐
- ☐ Other: (describe)

Questions to help determine whether an accommodation is needed (Under the ADA 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 if the requested accommodation is needed because of the disability)

3. What limitation(s) is interfering with job performance or accessing a benefit of employment?

4. What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)

5. How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

6. If this condition is episodic or in remission, please detail the frequency, severity, and duration of the current or anticipated future episodes. If this condition is not episodic or in remission you may skip this question.

7. What specific accommodation(s) could you recommend or suggest that would allow the employee to perform the essential functions of their current job.

8. Is there any additional information that would be helpful to us in determining the appropriate accommodation(s) for the employee

Verification	
I, the undersigned, affirm that I have provided the information above and that said information is true and correct to the best of my knowledge and belief.	
Medical Professional's Signature:	Date:
Print Name:	
Address:	Email:
Phone:	Fax:

Please return completed form to:
ADA Coordinator
Salt Lake County
2001 So. State St., Ste N4-700
Salt Lake City, UT 84190-3150
Or by fax to 385-468-0557