DEPARTMENT OF EMPLOYEE RELATIONS
Disability Medical Information Request Form

ADAAA/WFEA
POLICY AND COMPLIANCE MANUAL
December 2015

NOTE TO MANAGER: This form must be tailored to the employee's specific impairment and requested accommodation; care must be taken to ensure unrelated health care information is not solicited. It is highly recommended that this form be augmented by a letter to the health care provider that details the observable, job-related concerns (if applicable), a description of the nature and setting of the job and a copy of the job description.

Employee:	
Position Title:	
Department/Division:	
Supervisor:	
Supervisor Phone:	
Supervisor Email:	

This form must be completed by the physician/health care provider and returned as soon as possible and no later than <2 weeks if initial request or 7-10 calendar days, if follow-up request > to:

Manager Name
Manager Job title
Department
Address
Milwaukee, WI 53202

Email: abcdef@milwaukee.gov
Telephone (414) 286-XXXX
Private FAX (414) 286-XXXX

Employee of the **City of Milwaukee Department** has indicated that he or she has a medical condition that may require reasonable accommodation(s) under the Americans with Disabilities Act Amendment Act (ADAAA) in order to perform the essential functions of the employee's position, as **Job Title**. A copy of the employee's job description is attached.

INSERT PERTINENT WORK & MEDICAL HISTORY –

In order to qualify for reasonable accommodation under the ADAAA, an employee must have an impairment that substantially limits one or more major life activities or a record of such impairment. The following questions may help determine whether an employee has a disability under this definition.

1. Does the employee have a physical or mental impairment? □ Yes □ No

2. If *yes*, what is the employee's impairment or nature of the impairment?

   RESPONSE:

   _____

   _____

3. Does the impairment limit a major life activity as compared to most people in the general population? □ Yes □ No

4. If the answer to Question 3 is *yes*, describe the limitations on a major life activity/activities:
   a. Walking (including ascending and descending stairs):

   b. Speaking:

   c. Breathing:

   d. Sitting:

   e. Standing:

   f. Lifting:

   g. Performing manual tasks:

   h. Seeing:

   i. Hearing:

   j. Caring for oneself:

   k. Working:

   l. Sleeping:

   m. Concentrating:

   n. Thinking:

   o. Communicating:

   p. Eating:

   q. Other (e.g., cognitive abilities, thinking, organizing, alphabetizing, etc.):

5. Is the disability:

Permanent	☐	**Temporary**	☐	**Intermittent**	☐
Chronic	☐	**Progressive**	☐	**Other**	☐

   If other, please describe: _____

   _____

6. What is the extent and/or duration of the disability?

   _____

   _____

7. Is the employee presently in treatment for the disability? □ Yes □ No

8. If the answer to Question 7 is *yes*, are special accommodations in the employee's work schedule necessary in order to continue employment? □ Yes □ No

   If *yes*, please specify frequency and duration of schedule change.

   _____

   _____

9. Questions based upon a review the job description:

   a. Can the employee perform the essential functions of the job and the accompanying duties and tasks, with or without reasonable accommodation(s)? □ Yes □ No

   b. If the employee can perform the essential functions of the job with accommodation(s), please describe the employee's medical restrictions that require accommodation in order for this employee to perform the essential functions of the position.

   RESPONSE:

   _____

   _____

   _____

10. What reasonable accommodations are needed at work to assist this employee in performing the essential functions of the position? Please explain why these modifications are necessary, including the medical reason.

    RESPONSE:

    _____

    _____

    _____

11. Is there any other information related only to the disability and associated reasonable accommodations of which the employer should be aware? Limit your response to the condition for which the employee is seeking accommodation(s).

    RESPONSE:

    _____

    _____

    _____

Disability Medical Information Request Form *completed by:*

Signature of Physician/Health Care Provider	
Physician/Health Care Provider Name (printed)	
Address	
City, State, Zip	
Telephone Number	
Date	

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.

The City of Milwaukee Department of Employee Relations, reserves the right to review the above information and make an independent decision. All information is confidential in accordance with the Federal Americans with Disabilities Act (ADA); information may be shared with the hiring authority, supervisors and managers in order to provide reasonable accommodation or required treatment in case of an emergency.