**MEDICAL ASSESSMENT FORM**

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| 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 ask that you not provide any genetic information when responding to this medical information request. “Genetic information” 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. |

**Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The employee may not complete the document. It must be completed and signed by the health care provider.**

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| Does the employee have a physical or mental health impairment? | Yes ☐ No ☐ |
| If yes, please describe the nature, severity, and expected duration of this condition:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Do(es) the impairment(s) limit the employee’s activities? | Yes ☐ No ☐ |
| Is the employee able to perform the job duties/requirements outlined in the attached position description? | Yes ☐ No ☐ |
| Will the employee have limitations that affect his/her ability to perform the job duties/requirements outlined in the attached job description? | Yes ☐ No ☐ |
| If yes, please check the applicable boxes below indicating the employee’s limitations:  **If the box is checked, but no restrictions are specified, we will interpret it to mean that the employee cannot perform the function. If no expected duration is provided, we will understand this to mean the restriction or current functioning level is permanent.**   |  |  | | --- | --- | | **Restriction (check all that apply)** | **Description of restriction and expected duration** | | Standing……………..☐ |  | | Walking……………...☐ |  | | Sitting………………..☐ |  | | Stretching/reaching…..☐ |  | | Bending……………....☐ |  | | Crawling……………...☐ |  | | Balancing……………..☐ |  | | Climbing stairs………..☐ |  | | Vision………………....☐ |  | | Hearing (in person).......☐ |  | | Hearing (telephone)......☐ |  | | Driving………………..☐ |  | | Lifting more than  \_\_\_\_lbs………………..☐ |  | | Turning………………..☐ |  | | Twisting………….……☐ |  | | Kneeling……………....☐ |  | | Pulling………………...☐ |  | | Wearing PPE (Personal protective equipment). i.e., steel-toed shoes, respirator, hearing protection, etc. ..………………....☐ |  | | Working onsite at an office location..……………...☐ |  | | Working offsite in a community setting or private homes………....☐ |  | | Working in stressful/high conflict situations……..☐ |  | | Working with individuals under the influence of drugs or alcohol or with physical or mental disabilities…………….☐ |  | | Working with vulnerable populations…………...☐ |  | | Working full-time…….☐ |  | | Working overtime…….☐ |  | | Memory……………....☐ |  | | Working in a team environment………….☐ |  | | Attention or  concentration………….☐ |  | | Performing physical interventions while working with a partner...☐ |  | | Lowering individuals to the floor……………......☐ |  | | Dropping repeatedly to the knees…………………..☐ |  | | Engaging in a combination of sitting, standing, laying on the ground, pivoting, walking backward, and other physical exertion...☐ |  | | Rolling an individual on the ground……………..☐ |  | | Performing hands-on compressions (2 inches deep)..............................☐ |  |   ☐ Other (please describe)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| How do(es) the employee’s impairment(s) interfere with their ability to their job functions?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| What accommodations or adjustments can be made to facilitate the employee’s return to work?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **For COVID-19 related concerns:** The Employer has implemented procedures to reduce the virus’s spread in our workplace, including [INSERT PROCEDURES]. Will these accommodations or adjustments allow the employee to return to work onsite and/or in the community?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If other accommodations or adjustments are required, what additional accommodations or adjustments can be made to facilitate the employee’s return to onsite work?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Will the employee need time off for appointments, other medical tests/treatment, recuperation, or flare-ups of this condition? If so:   1. How frequently do you anticipate the employee will be absent? \_\_\_\_\_\_\_\_ days per \_\_\_\_\_\_\_\_ (week or month). 2. How long do you anticipate the employee will need to be out of work for each occurrence? \_\_\_\_\_\_\_\_\_\_\_ hours or \_\_\_\_\_\_\_ days or \_\_\_\_\_\_ weeks. 3. How long do you anticipate that the employee will require time off at the above frequency?  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | |
| If requesting a leave of absence, when will  the employee be able to return to work?  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If the return to work date is unknown, please indicate this. If no response is given, we will interpret this to mean that indefinite leave is required.** | |

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Signature Date

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Printed Name of Health Care Provider