University of Houston-Downtown
Office of Human Resources

University of Houston-Downtown
Medical Inquiry Form

Employee Name: _____ Date: _____

Job Title: _____ Department: _____

The above employee has requested job modification based on a medical condition. The relevant portions of their job description is included in the chart below. Please complete the chart to best of your ability, and attach additional pages if necessary.

The University of Houston requires diagnostic documentation from a licensed medical, psychological or other diagnostic professional (such as an audiologist for hearing impairments) when an employee is making a request for accommodations based on disability. It will benefit both the employee and UH for you to complete this form as specifically as possible. Feel free to attach any relevant supplementary documentation.

When answering the first five questions, please do not take into consideration any remedial effects of mitigating measures such as medications, medical supplies, equipment or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies, use of assistive technology, reasonable accommodations already in place, auxiliary aids or services, or learned behavioral or adaptive neurological modifications.

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 (75 Fed. Reg. 68934).

Please contact HR Benefits at 713-221-8060, if you have any questions about completing this form. Your assistance is greatly appreciated!

Please return directly to:

HR Benefits Office
One Main Street, Suite 910S
Houston, TX 77002
Fax: 713-223-7496

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1. Diagnosis/es: _____

2. Does the employee have a physical or mental impairment? ◯ Yes ◯ No

3. What is the impairment? _____

4. Is the impairment: ◯ Short Term ◯ Long Term ◯ Permanent

If *not* permanent, how long will the impairment likely last? _____

5. Does the employee's impairment substantially limit any major life activities? ◯ Yes ◯ No

If so which major life activities are limited?

_____

_____

6. Cause of condition(s):

_____

_____

_____

7. Is this condition(s) degenerative? ◯ Yes ◯ No If yes, please elaborate.

_____

_____

_____

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Following are essential functions, duties and physical requirements of this employee's job. Please evaluate their ability to perform each function and to meet each requirement without accommodation of any kind. UHD will then determine, with input from the employee, whether any accommodations are needed and if so, what is reasonable.

Rating Code:
1 = no limit on employee's ability to perform
2 = partial limit on employee's ability to perform (explain)
3 = employee cannot perform this function (explain)
0 = unable to rate

Job Title: _____

Summary:

Job Duties	Rating	Accomodation Suggestions/Comments
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

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Supervisory Responsibilities	Rating	Accomodation Suggestions/Comments

Work Location	Rating	Accomodation Suggestions/Comments

Physical Demands	Rating	Accomodation Suggestions/Comments

Physician's Signature

Typed or Printed Name of Physician

Title

Print Physician's Office Address

Physician's Telephone Number(s)

Date Form Was Completed