

Date: \_\_\_\_\_

Re: \_\_\_\_\_

To whom it may concern:

The above patient is an employee of our university and has requested a reasonable accommodation for his/her disability. In order to fulfill our responsibility as an employer under the Americans with Disabilities Act, specific information is being requested at this time. A Release of Information is attached to this document.

**Please do not send copies of medical records.** We are not authorized to have medical records and are not qualified to interpret them. Please read through all of the attached questions and answer them to the best of your ability. Thank you in advance for your prompt reply to this brief inquiry. The form should be returned to the address listed below. If you prefer to discuss this on the telephone, please feel free to contact me at 651-793-1278.

Sincerely

*Stephanie A. Miller*

Stephanie A. Miller  
Director of Human Resources  
Metropolitan State University  
700 E. Seventh St.  
St. Paul, MN 55106

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Does this individual currently have a physical or mental impairment?

If yes, what is the diagnosis?

\_\_\_\_\_

2. Does this impairment substantially limit one or more major life activities? (Major life activities are those which an average person can perform with little or no difficulty, such as walking, talking, hearing, seeing, thinking, concentrating, working with others, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Describe the nature, severity and anticipated duration of the impairment.

Temporary (explain)

\_\_\_\_\_

\_\_\_\_\_

Temporary but will take longer than normal to heal (explain)

\_\_\_\_\_

\_\_\_\_\_

Anticipated healing period

\_\_\_\_\_

Temporary with residual effects (explain)

\_\_\_\_\_

\_\_\_\_\_

Permanent

\_\_\_\_\_

Chronic (explain)

\_\_\_\_\_

\_\_\_\_\_

4. If your response to questions 1 and 2 is that the employee has an impairment that substantially limits one or more major life functions, please list what, if any, medications and/or other corrective measures are currently prescribed to control or eliminate the individual's symptoms and/or limitations. Please describe how the impairment is mitigated and include information about any side effects that the individual experiences in light of the use of the medications and/or corrective measures outlined.

---

---

5. Please list any specific functional limitations resulting from the impairment.

---

---

---

---

6. The essential functions of this individual's current job include:

---

---

---

7. How do the functional limitations listed impact the individual's ability to perform the essential functions identified?

---

---

---

8. If you answered "Yes" to question #1, are there any reasonable accommodations you would suggest that may enable him/her to perform the essential functions identified? If so, what suggestions do you have?

---

---

---

---

Doctors Signature

Date