LANE COMMUNITY COLLEGE
MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

(To be completed by the employee's physician)

A. LCC Employee/Patient's Name:

B. Questions to help determine whether an employee has a disability:

The following questions are to help determine whether the employee has a disability under the ADA (i.e. if the person has an impairment that substantially limits one or more major life activities):

Does the employee have a physical or mental impairment?	Yes	No
What is the impairment and diagnosis code?		
Please include the date of the most current diagnostic evaluation and the date of the original diagnosis.		
Is the impairment long-term or permanent?	Yes	No
If *not* permanent, how long will the impairment likely last?		
What is the expected progression or stability over the next five years?		
Does the impairment affect a major life activity?	Yes	No
If *yes*, what major life activity(s) is/are affected?		
Is the employee substantially limited in one or more of these major life activities? (*Substantially limited* means the individual is unable to perform or is significantly limited in the ability to perform a major life activity compared to an average person in the general population)	Yes	No
What major life activity/activities is the employee substantially limited and how is the employee's ability to perform the activity affected by the impairment?		

C. Questions to determine whether an accommodation is needed.

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 whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with job performance?

What job function(s) is the employee having trouble performing because of the limitation(s)? (Refer to attached job description)

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

If an employee has a disability and needs an accommodation because of the disability, do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

E. Comments.

_____/_____/_____

Medical Professional's Signature **Name (please print)** **Date**

_____/_____

Company Name **Phone number**

_____/_____/_____

Address **City State** **Zip**

Return this form to the ADA Coordinator at:
LCC Human Resources
4000 E 30th Avenue Bldg 3
Eugene, Oregon 97405

If you have any questions about this process, please contact the ADA Coordinator at 541-463-5589.