Workplace Accommodation Request

Questionnaire for Health Care Provider Forms

Instructions for Employee Completion

Health Care Provider

The Questionnaire for Health Care Provider should be completed by a licensed health care provider with knowledge of the patient's medical or psychological condition(s).

How to use the interactive form:

1. Open PDF document in Adobe Acrobat
2. Click the "Fill & Sign" tool in right pane
3. Complete form filling by clicking a text field and typing
4. Once forms are completed, send via email to dx.randa@disney.com or you can upload the form directly to your case in My Requests in ***D Tools HR***.

Questionnaire for Health Care Provider
Regarding Workplace Accommodation Request

Employee's Name: _____

[*Employee*] has requested a workplace accommodation from [*Employer*]. Please provide us with the following information to enable us to determine how to assist [*Employee*].

Please do not disclose the employee's underlying medical condition or diagnosis, or any genetic information.

1. Does the employee have a medical condition or disability that limits any major life activities?

   ☐ Yes ☐ No

   (Examples of major life activities include but are not limited to caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include the operation of major bodily functions, including but not limited to functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.)

2. Please describe the physical or mental limitations/restrictions resulting from the employee's medical condition or disability.

   _____
   _____
   _____
   _____

3. Are the employee's limitations/restrictions permanent or temporary? ☐ Permanent ☐ Temporary

   a. If temporary, what is the expected duration of the limitations/restrictions?

      _____
      _____
      _____

4. Do the employee's limitations/restrictions interfere with their ability to perform any of their job duties?

   ☐ Yes ☐ No

   a. If yes, please describe which job duties and explain how the employee's limitations interfere with their ability to perform those job duties.

      _____
      _____
      _____
      _____

5. Are there any job duties the employee cannot perform at all? ☐ Yes ☐ No

    a. If yes, please identify:

    _____

    _____

    _____

6. Please provide your medical opinion about what specific accommodation(s) would allow the employee to perform their job duties.

    _____

    _____

    _____

    _____

7. How long do you anticipate the employee will need the accommodation(s) identified?

    _____

    _____

    _____

8. Is there any additional information that you believe is relevant to the employee's accommodation request?

    _____

    _____

    _____

Health Care Provider Name: _____ Date: _____

Health Care Provider Signature: _____ Medical Specialty: _____

Phone Number: _____ License# / State: _____

Address: _____

_____