

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***.

Workplace Accommodation Request

QUESTIONS FOR EMPLOYEE:

In keeping with the Company's Equal Employment Opportunity policy, the Company provides reasonable accommodations for employees with physical or mental disabilities. If you need an accommodation for a physical or mental condition that is interfering with job performance, please complete this request form. The information will help the Company evaluate how your disability or medical condition limits you in the workplace and identify whether there are any reasonable accommodations.

When completing the form, please do not disclose your underlying medical condition or diagnosis, or any genetic information.

1. Do you 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 your medical condition or disability:

3. Are your limitations/restrictions permanent or temporary? ☐ Permanent ☐ Temporary

- a. If temporary, what is their expected duration?

4. Are you having trouble performing any job duties because of your limitations/restrictions?

☐ Yes ☐ No

- a. If yes:

- i. Which job duties?

- ii. How do your limitations interfere with your ability to perform your job duties?

iii. Are there any duties that you cannot perform at all?

5. Are there any specific accommodations that will enable you to perform your job duties?

☐ Yes ☐ No

a. If yes, please describe:

6. How long do you anticipate needing the accommodation(s) identified?

7. Is there any additional information that you believe is relevant to your accommodation request?

8. Are you currently receiving any workplace accommodations for your medical condition or disability?

☐ Yes ☐ No

a. If yes, please describe:

Name: _____

Date: _____

Signature: _____

Candidate Number: _____

Program Start Date: _____

Program End Date: _____

Phone Number: _____

Email Address: _____

**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: _____
