ADA REQUEST FOR REASONABLE ACCOMMODATION
HEALTH CARE PROVIDER QUESTIONNAIRE

To: *Health Care Provider*

Employee Name: _____ **Job Evaluated:** _____

_____ ("Employee") is an employee of ArentFox Schiff LLP (the "Firm"). This Employee has requested an accommodation under the Americans with Disabilities Act and state and local counterparts (the "ADA") to enable the Employee to perform the essential functions of his/her job, and has identified you as his/her health care provider. To assist the Firm in evaluating this request for an accommodation, please provide detailed answers to the questions. We need your complete medical opinion, so please fully answer each question. The information you provide will be considered confidential to the extent required by applicable law and used only to evaluate the employee's request for an accommodation. Thank you for your cooperation.

Please return the completed form to ***Patricia Griffin, Human Resources and Benefits Specialist, ArentFox Schiff LLP, 233 South Wacker Drive, Suite 7100, Chicago, IL 60606*** **by _____, 2023 via mail or fax at 312.258.4570**.

IMPORTANT NOTE TO HEALTH CARE PROVIDER: When answering these questions, please do not take into consideration any ameliorative 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 or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

Please answer the following questions based on your medical evaluation of the Employee.

1. **Does the Employee have a physical or mental impairment?** ☐ Yes ☐ No

   a. If yes, what is the nature of the impairment? _____

   _____

   _____

   b. Based on reasonable medical certainty, what is the duration or expected duration of the impairment? _____

   _____

2. **Does the Employee's impairment substantially limit any major life activities?** ☐ Yes ☐ No

   Note: *Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.*

a. If yes, what major life activities, including major bodily functions, are affected?

Major Life Activities

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking
☐ Breathing	☐ Interacting With Others	☐ Reading	☐ Standing
☐ Caring For Self	☐ Learning	☐ Seeing	☐ Thinking
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working
☐ Other (describe below)			

_____

_____

_____

Major Bodily Functions

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	
☐ Circulatory	☐ Immune	☐ Operation of an Organ	☐ Other (describe below)

_____

_____

_____

3. **Describe how this Employee is substantially limited in each major life activity identified above as compared to the way in which an average person in the general population can perform that activity.** Such information can include how the Employee is restricted as to the condition, manner, or duration under which the activity can be performed.

_____

_____

_____

4. **Have you placed medical restrictions on the Employee for this impairment?** ☐ Yes ☐ No

a. If yes, what are the restrictions? Indicate if the restrictions are ☐ permanent or ☐ temporary.

_____

_____

_____

b. *If restrictions are temporary*, please provide the date on these restrictions will:

☐ expires _____

☐ be revaluated _____

Please answer the following questions based on your review of the Employee's job description.

5. **Can the Employee perform all job functions without restrictions?** ☐ Yes ☐ No

a. If no, which job functions, cannot be performed in light of the Employee's impairment or medical restrictions?

_____

_____

_____

b. For how long will the Employee be unable to perform the listed job functions due to his/her impairment or medical restrictions? Please specify any work hours restrictions, required breaks, weight limits, etc.

_____

_____

_____

6. **Do you have any suggestions regarding possible reasonable job accommodations that would allow the Employee to be able to perform the essential functions of his/her job?** ☐ Yes ☐ No

Note: *Please be aware that if you will be recommending telework as a possible accommodation, the Firm must understand why telework (outside of the Firm's current in-office work expectation of 60%) is being requested and what limitation led to the request.*

a. If yes, what are those accommodations?

☐ Part-time schedule ☐ Adjusted schedule	☐ Breaks during work day ☐ Leave of absence	☐ Other (describe below)

_____

_____

b. Please provide additional detail on your recommendation, such as recommended work schedule, break periods, duration of leave of absence, etc. and how this recommendation would improve the Employee's ability to perform the essential functions of his/her job.

_____

_____

_____

_____

_____

c. If you are recommending telework that is outside of the Firm's current in-office expectation, please provide specific detail on why telework is being recommended and if there are other accommodations that may also be a reasonable accommodation for this Employee.

_____

_____

_____

7. **Would performing any of the job functions listed result in a direct safety or health threat to the Employee or others, such as colleagues, members of the general public, etc.?** ☐ Yes ☐ No

a. If yes, what job function(s) would pose a threat? _____

_____

_____

b. If yes, what is the direct safety or health threat? _____

_____

_____

c. If yes, are there any reasonable accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level? _____

_____

_____

_____ _____ _____

Signature of Health Care Provider Title Date

Printed Name and Address:

_____

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GINA Notification to Health Care Providers: 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 employees or their family members. In order 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.