

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
MEDICAL INQUIRY FORM

This form must be completed by a medical provider and returned to OEOCR within 30 calendar days of receiving it.

Employee Name: [Click here to enter text.](#)

Does the employee have a physical or mental impairment?

☐ Yes ☐ No

What is the impairment/diagnosis?

[Click here to enter text.](#)

What is the expected duration of the impairment (x months, x years, or permanent)

[Click here to enter text.](#)

Does the impairment affect a major life activity?

☐ Yes ☐ No

If yes, what major life activity(s) is/are affected?

- | | | | |
|--|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Caring For Self | <input type="checkbox"/> Walking | <input type="checkbox"/> Hearing | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Interacting With Others | <input type="checkbox"/> Standing | <input type="checkbox"/> Seeing | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Thinking | <input type="checkbox"/> Learning | <input type="checkbox"/> Reproduction |
| <input type="checkbox"/> Working | <input type="checkbox"/> Toileting | <input type="checkbox"/> Sitting | |

☐ Other. Please describe: [Click here to enter text.](#)

Is the employee substantially limited in one or more of these major life activities? (To be considered substantially limiting, an impairment does not need to prevent or severely restrict a major life activity).

☐ Yes ☐ No

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Please describe how the employee's limitation(s) interfere with their ability to perform the job function(s)

Click here to enter text.

Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

Click here to enter text.

If you have any additional comments, please include them below:

Click here to enter text.

*** For verification of signature, please attach a business card or stationary with your letterhead.**

Print Name_____

Signature_____

Date_____