

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**\_\_\_\_\_