



**City of Philadelphia ADA Accommodation Request
 Health Care Provider Form**

Name of Employee: _____ Payroll # _____

Job Class ID: _____ Employee Job Title: _____

Health Care Provider Name: _____

Health Care Provider Phone Number: _____

INTERACTIVE PROCESS QUESTIONNAIRE *(To Be Completed by the Employee's Physician)*

Please answer and return the following questionnaire to your patient. We appreciate your response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Please also refer to the attached job description regarding employee duties. **By submitting this form to us, the employee has also consented to HR staff reaching out to you for more information as needed.** Thank you for your cooperation.

1. Does the above employee have a physical or mental impairment? ____Yes ____No

If so, please state the type of impairment:

2. Does the impairment substantially limit any major life activities? ____Yes ____No

3. If so, which major life activity or activities are limited?

4. For each major life activity that is limited by the impairment, please describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity:

5. What is the duration or expected duration of the impairment?

6. Attached is a job description for the specific position. Please review the job description. Are there any job functions the employee is unable to perform without an accommodation?

Yes No

7. If not, which job functions cannot be performed, and why not? _____

8. Please describe what reasonable accommodation(s) would allow this employee to perform their job functions **and** how the recommended accommodation(s) address(es) the employee's functional limitations.

9. Would performing any of their job functions, with accommodations as needed, result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc.)?

Yes No

10. If yes, please describe:

a. What job function(s) would pose such a threat: _____

b. The direct safety or health threat posed: _____

c. Any reasonable accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level: _____

Signature

Title

Medical License Number

Date

Printed Name and Address:
