DEPARTMENT OF LABOR
AMERICANS WITH DISABILITIES ACT (ADA) REASONABLE ACCOMMODATION REQUEST

HEALTHCARE PROVIDER QUESTIONNAIRE

For DOL Employees Only - DOL Form 306

Patient (Employee) Name:

Job Title: **Unit:**

Office Location: **Direct Supervisor' Name:**

I, _____ understand that you may have questions about my request and may need to contact my health care provider. I hereby give you permission to do so. In addition, I give my health care provider permission to discuss the bases of my request with the Office of Diversity and Equity Programs (ODEP). I attest that I have attached a copy of my DAS job description to this form for my healthcare provider's reference when completing this form.

Employee Signature & Date: _____

********** FOR HEALTHCARE PROVIDER USE ONLY **********

Please do not complete this form unless the above-named patient has attached their job description to this form for your reference. Your patient (named above) has made a request for a reasonable. To process this request, please complete this form in its entirety by responding to all of the questions below. Please feel free to attach additional pages if necessary.

Healthcare Provider's Name:

Type of Practice:

Address: **City:** **State:** **Zip Code:**

Telephone #: **E-mail Address:**

1. Were you provided the above-named patient's job description as an attachment to this form?
   Yes **No** **(If "No", do not complete this form until you received the job description)**
2. Does the above-named patient have a physical or mental impairment? **Yes** **No**
3. Date when the impairment began.
4. Date you first examined the above-named patient regarding this impairment.
5. Date you last examined the above-named patient regarding this impairment.
6. Follow-up date you will examine the above-named patient regarding this impairment.
7. What is the condition of the above-named patient's impairment?
   Temporary _____ Chronic _____ Permanent _____
8. Is the above-named patient receiving other forms treatments for this impairment other than the treatment you provide? **Yes** **No**
   a. If yes, what other forms of treatment for this impairment is the above-named patient receiving? Ex: physical therapy, dialysis, chemotherapy, etc.

b. If yes, how frequent does/will the above-named patient receive these other forms of treatment? Ex: Twice a week, once a month, etc.

9. Does the impairment substantially limit one of more of the above-named patient's major life activities or bodily functions? **Yes** **No**

a. If yes, what major life activities or bodily functions does the above-named patient's impairment substantially limit? Ex: the inability to reach, groom, stand, bend, grip, concentrate, speak, hold bladder, etc.

b. If yes, what is the expected duration each major life activity or bodily function (listed in 9a) will be substantially limited? Ex: 1 month, 6 months, or 1 year.

10. Will the employee be limited in their ability to perform their job as listed in the attached job description, if no accommodation is granted? **Yes** **No**

a. Please list each task/duty in the attached job description the above-named patient is unable to or limited in their ability to perform and the anticipated duration of such inability or limitation. Ex: Typing for longer than 2 hours without a 15 min rest before starting to type again for another 2 hours.

11.

12. Is the patient's condition chronic? **Yes** **No**

a. If so, how long have you had the condition?
b. How long is the condition expected to last?
c. Is the condition permanent?
d. Is the condition triggered by anything? If so, what?

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13. Based on your knowledge of the above-named patient's impairment, are there any accommodations the employer can make that you believe would permit the above-named patient to perform the tasks/duties you listed in 10a? **Yes** **No**

a. If yes, what accommodation do you recommend the employer implementing. Please be as detailed as possible.

b. If yes, how long do you recommend that the employer provide this accommodation to the above-named patient? Ex: 6 months

Healthcare Provider Declaration

I understand that I am providing information to assist the Commission on Human Rights and Opportunities in determining whether it can provide a reasonable accommodation for my patient _____. I certify that the information I am providing is true and correct and accurately reflects my medical assessment and opinion.

_____ License #: _____
Healthcare Provider's Name (Please Print Legibly)

_____ Date: _____
Healthcare Provider's Signature (MM/DD/YYYY)

_____ Address: _____
Name of Practice _____
_____

Phone Number: _____ E-mail: _____

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Under confidential cover, please e-mail (preferred) or fax this completed and signed form with the job description attached to:

Jeri D. Beckford
EEO Specialist II & ADA Coordinator
Jeri.D.Beckford@ct.gov or 860.263.6699 (fax)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information or an individual or family member of the individual, except as specifically allowed by this law. 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 and individual or family member receiving assistive reproductive services.

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Date Received: _____ **Received by:** _____