HEALTH CARE PROVIDER QUESTIONNAIRE
FOR THE PURPOSE OF PROVIDING REASONABLE ACCOMMODATION

Employee Name: ____________________________________________

Employee’s Position: _________________________________________

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.

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 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 an individual or family member receiving assistive reproductive services.

Does the employee have a physical or mental impairment? Yes ________ No ________
(An impairment is a physiological disorder affecting one or more body systems, or a mental or psychological disorder, including, but not limited to, the conditions listed below.)

If yes, what is the impairment? ____________________________________________________________________

Please circle any of the following conditions, without regard to severity, unless otherwise indicated, that the employee may have.

- Acquired Brain Injury
- Amyotrophic Lateral Sclerosis
- Blindness or abnormal vision loss
- Major Depressive Disorder
- Deafness or abnormal hearing loss
- Substantial disfigurement
- Kidney or Renal Diseases
- Major Depressive Disorder
- Pervasive Developmental Disorders
- Rheumatoid Arthritis
- Chronic Obstructive Pulmonary Disease
- Absent, artificial or replacement limbs, hands, feet or vital organs
- Alcoholism
- Bipolar Disorder
- Cerebral Palsy
- Lupus
- Diabetes
- Heart Disease
- Mental Retardation
- Multiple Sclerosis
- Parkinson’s Disease
- Schizophrenia
- Cancer
- Crohn’s Disease
- Cystic Fibrosis
- Epilepsy
- HIV or AIDS
- Mastectomy
- Muscular Dystrophy
- Paralysis

Is the employee currently impaired, or is the impairment episodic or in remission? ______________________

What is the anticipated duration of the impairment? ______________________

If the actual or expected duration is more than six months, does the condition impair the employee’s physical or mental health to a significant extent as compared to what is ordinarily expected in the general population? Yes ________ No ________

If yes, please describe how the impairment impairs the employee’s physical or mental health
Does the impairment require special education, vocational rehabilitation or related services?
Yes  ______  No  ______  If yes, please describe: ____________________________

Please circle any of the following major life activities are affected by the impairment.

Walking  Speaking  Breathing  Caring for Oneself
Hearing  Seeing  Thinking  Communicating
Reading  Standing  Reaching  Interacting with Others
Learning  Lifting  Concentrating  Performing Manual Tasks
*Working  Sleeping  Eating  Bending
**Major Bodily Functions (Describe)  ____________________________
Other (Describe)  __________________________________________

*If working is an activity affected by the impairment, please indicate the class of jobs, or broad category of work, which is affected by the impairment.

**Major Bodily Functions include, but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Does the impairment substantially limit the employee’s ability to perform such major life activities?
Yes  ______  No  ______

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:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Based on your understanding of the employee’s job requirements, please assess whether the employee can perform all job functions:  Yes  ______  No  ______

If not, which job functions cannot be performed, and why not?  __________________________________________

____________________________________________________________________

What reasonable accommodation(s), if any, would you recommend for the employer to consider in order to enable the employee to work?  __________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Would performing any of the job functions result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc.)?  Yes*  ______  No  ______

* If yes, please describe:

(a) which job function(s) would pose such a threat:  __________________________________________

____________________________________________________________________

____________________________________________________________________
(b) the direct safety or health threat posed: ________________________________

______________________________

(c) any reasonable accommodations that would eliminate or reduce such threat: ____________

______________________________

Signature ___________________________ Date ___________________________

Printed Name _______________________

Occupation ________________________
State of Maine
Department of Administrative & Financial Services

Certificate Authorizing Release of Medical/Health Care and Personnel Information

Employee Name: ____________________________________  Home phone: ____________________

Address: __________________________________________________________________________

Job Class Title: _____________________________________________________________________

Health Care Provider: __________________________________________________________________

Address: __________________________________________________________________________

I authorize my employer to obtain medical records and information from my physician, osteopath, chiropractor, therapist or other health care provider for the specific purposes of:

- determining whether I have a disability under the Maine Human Rights Act, the Americans with Disabilities Act, and/or the Rehabilitation Act of 1973;
- determining the effect of the disability on performance of essential job functions; and/or
- determining appropriate reasonable accommodations.

I understand that any medical records or other information will be released only for the purposes stated above and will be maintained in a separate location from my personnel file and will remain confidential except to the extent necessary to make the determinations stated above.

This authorization includes substance abuse treatment records to the extent necessary to make the above determinations. (See PL-92-225, PL 93-382, 42 CFR Part 2).

Unless I revoke this release, it will remain in effect for one year from this date. I am entitled to a copy of this release.

I have the right at any time to revoke this release and to refuse authorization to disclose all or some medical information, but my revocation or refusal may result in denial of my request for reasonable accommodation. I can revoke this release by providing written notice to my personnel officer or the departmental equal employment opportunity coordinator.

I also hereby authorize my employer, the State of Maine, to release to my health care providers any and all documents related to me and my employment with the State of Maine, including, but not limited to: workers’ compensation information, medical information of any kind, performance evaluations and personal references submitted in confidence, complaints, charges, or accusations of misconduct, replies to those complaints, charges or accusations and any other information or materials that may result in disciplinary action.

Employee Signature: ___________________________  Date: ________________________

Revised 4/09
EMPLOYEE’S REQUEST FOR REASONABLE ACCOMMODATION(S)

Employee Name: _____________________________   Home phone: _____________________________

Address: ____________________________________________________________________________

Job Class Title: ________________________________________________________________________

Employment status (circle): Full Time     Part Time     Seasonal     Applicant

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Nature of impairment / condition: _____________________________________________________________________________________________

Do you have any of the following conditions? If so, please circle the appropriate condition(s):

- Acquired Brain Injury
- Amyotrophic Lateral Sclerosis
- Blindness or abnormal vision loss
- Major Depressive Disorder
- Deafness or abnormal hearing loss
- Substantial disfigurement
- Kidney or Renal Diseases
- Major Depressive Disorder
- Pervasive Developmental Disorders
- Rheumatoid Arthritis
- Chronic Obstructive Pulmonary Disease
- Absent, artificial or replacement limbs, hands, feet or vital organs

Acquired Brain Injury   Alcoholism
Amyotrophic Lateral Sclerosis   Bipolar Disorder
Blindness or abnormal vision loss   Cerebral Palsy
Major Depressive Disorder   Lupus
Deafness or abnormal hearing loss   Diabetes
Substantial disfigurement   Heart Disease
Kidney or Renal Diseases   Mental Retardation
Major Depressive Disorder   Multiple Sclerosis
Pervasive Developmental Disorders   Parkinson’s Disease
Rheumatoid Arthritis   Schizophrenia
Chronic Obstructive Pulmonary Disease

Date that impairment/condition began: ________________________________________________

Anticipated duration of the impairment/condition, including whether the impairment is current, episodic, or in remission: ________________________________________________

Please list special education, vocational rehabilitation or related services, if any, that your impairment/condition requires: ________________________________________________

Please circle any of the following major life activities are affected by the impairment.

- Walking
- Hearing
- Reading
- Learning
- *Working
- **Major Bodily Functions (Describe)
- Other (Describe)

**Major Bodily Functions include, but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

*If working is an activity affected by the impairment, please indicate the specific tasks or duties of your work that are affected by the impairment, and what functions you are still able to perform.

__________________________________________________________________________________
I am requesting the following accommodations or modifications to my employment:

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature of Employee</th>
<th>Date:</th>
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Request Received By: ___________________________ Date: ___________________________