Office of Human Resources
3401 CSM Drive, San Mateo, CA 94402
Tel: (650) 574-6555 ● Fax: (650) 574-6574

MEDICAL PROVIDER QUESTIONNAIRE

Employee Name: ___________________________ G#: __________________________

Telephone: ________________________________ Email: ________________________

1. Does the Patient have a physical or mental impairment that limits her ability to engage in a major life activity such as the ability to work; care for self; perform manual tasks; walk, see, hear, eat, sleep; or engage in social activities? (Pursuant to the FEHA amendments that went into effect on January 1, 2001, a condition can be said to limit a person if the condition makes the achievement of a major life activity more difficult.)

   ☐ NO, the Patient does not have a physical or mental impairment that limits her ability to engage in a major life activity.

   ☐ YES, the Patient has a ☐ PHYSICAL and/or ☐ MENTAL impairment that limits her ability to engage in a major life activity.

2. If the answer to question 1 is yes, does the impairment currently affect the Patient's ability to perform the essential job functions (see attached job description)?

   ☐ NO, the Patient's impairment does not limit their ability to perform all of the essential functions of the position.

   ☐ YES, the Patient's impairment does affect their ability to perform the essential functions of the position.

3. If the answer to question 2 is yes, what work restrictions or functional limitations does their disability produce that are in need of accommodation? Please be as specific as possible (e.g., if providing a restriction to standing, how many minutes can the subject stand before they would need to sit for X minutes). **List all necessary work restrictions with sufficient detail so all parties will understand how to interpret and apply them.**

   ☐ Restrictions are **TEMPORARY through __________ (date)**

   ☐ Restrictions are **PERMANENT**

List all physical activity restrictions.

- ☐ NO repetitive lifting/carrying of _______lbs. or more
- ☐ NO repetitive bending/stooping > ____ times/row
- ☐ NO lifting/carrying of _______lbs. or more
- ☐ NO repetitive squatting/kneeling > ____ times/row
- ☐ NO repetitive pushing/pulling of ______lbs. or more
- ☐ NO prolonged standing in excess of ____ min.
- ☐ NO pushing/pulling of ______ lbs. or more
- ☐ NO prolonged sitting in excess of ____ min.
- ☐ NO at (or above) shoulder level reaching > ____ sec./min.
- ☐ Must alternate sitting/standing every _____ min.
- ☐ NO repetitive keyboarding in excess of ____min. per hour
- ☐ NO running / jumping / climbing (circle your answer)
- ☐ NO prolonged walking in excess of ____minutes
- ☐ Other (please be specific)

ADDITIONAL CLARIFICATION/ RESTRICTIONS ____

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4. Does the Patient's continued assignment to their job pose a significant risk of substantial harm to the health and safety themselves or others?

   ☐ NO
   ☐ YES, complete questions 5 and 6 below.

5. If the answer to question 4 is yes, identify the duration, nature, severity, likelihood, and imminence of each specific risk.

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6. If the answer to question 4 is yes, identify any specific work restrictions(s) that, if accommodated, would reduce or eliminate the risk(s) described in question 5.

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7. Please use the space below to include any additional information that you believe would be helpful to the interactive process for this employee.

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____ ______________________________
Physician's Signature Date

____ ______________________________
Print Physician's name Physician's license number

PLEASE FORWARD THIS COMPLETED FORM TO: Ingrid Melgoza/HR E-mail:melgozai@smccd.edu / Fax: (650) 574-6574 Mail to: Ingrid Melgoza/HR 3401 CSM Drive, San Mateo, CA 94402.