Date Provided to Employee (dd/mm/yyyy):_____ **Delivered by:**_____ **Method of Delivery:**_____

Job Accommodation Questionnaire

INSTRUCTIONS FOR COMPLETING THIS FORM

Employees should work with their Health Care Providers to complete this form. This form will assist Fairleigh Dickinson University in determining what accommodation(s), if any, could be provided to an employee to enable them to remain at work. The Health Care Provider should complete and sign Part 1 of this form. The employee should complete and sign Part 2 of this form. Employees must return this form fully completed within 10 calendar days of receiving this form from the University. **The completed form should be returned directly to Rose D'Ambrosio, Vice President of Human Resources, via Virtu (FDU's secure email server) at dambrosi@fdu.edu. If you do not have access to Virtu, please send Rose an email prior to emailing this form. Before completing this form, both the employee and Health Care Provider should review the GINA Compliance Notice that appears immediately below. Should it be determined by Human Resources, that your provider will need to review your job description, you will be notified.**

GINA Compliance Notice

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.

GENERAL INFORMATION

Employee Name: _____ Employee Position:_____

Employee's Work Location: _____

Health Care Provider Name: _____

Health Care Provider Business Address: _____

Health Care Provider Phone Number: _____

PART 1 – COMPLETED BY HEALTH CARE PROVIDER

1. Please describe the physical or mental impairment or medical condition prompting the employee's request or need for a reasonable accommodation:

   _____

   _____

2. Please list any specific functional limitations resulting from the impairment identified in your response to Question 1 (including limitations resulting from medication and/or other treatment) impacting the employee's ability to perform his/her essential job functions (e.g., cannot bend, stand, lift, push, pull, walk, climb, etc)?

   _____

   _____

3. Given the above-referenced functional limitations, please list below the specific essential function(s) you believe the employee is unable to perform due to his/her impairment. Please identify the underlying functional restriction(s) which prevents the employee from performing the essential function, and identify the expected duration of each outlined restriction. (Attach additional sheet if necessary.)

	Essential function	**Underlying Functional Restriction(s) Impacting Essential Function**	**Duration Of Restriction(s)**
i			
ii			
iii			
iv			

4. Are there any reasonable accommodations you would suggest that may enable the individual to overcome the functional limitations referenced above and thereby enable the individual to perform the essential function(s)? If so, please specify the reasonable accommodation and explain the factual and medical reasons why you believe the suggested accommodation is likely to be effective in addressing the individual's functional limitations (attach additional sheets as necessary).

_____

_____

Health Care Provider Signature: _____ Date: _____

PART 2 – COMPLETED BY EMPLOYEE

5. Can you perform the essential function(s) outlined in Question 3 with a reasonable accommodation? If yes, please recommend a reasonable accommodation that would enable you to perform the essential function(s).

	Can You Perform The Essential Function(s) Outlined In Question 3 With A Reasonable Accommodation?	**If Yes, Please Recommend A Reasonable Accommodation**
i	☐ Yes ☐ No	
ii	☐ Yes ☐ No	
iii	☐ Yes ☐ No	
iv	☐ Yes ☐ No	

Employee Name: _____

Employee Signature: _____ Date: _____

PART 3 - COMPLETED BY HUMAN RESOURCES REPRESENTATIVE WHEN COMPLETED FORM IS RETURNED

Human Resources Representative Name: _____ Date: _____