

**DTRA REASONABLE ACCOMMODATION REQUEST  
MEDICAL INQUIRY FORM**

# CUI

## ATTENTION

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POC:

## ATTENTION

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Access to and dissemination of Controlled Unclassified Information shall be allowed as necessary and permissible to any individual(s), organization(s), or grouping(s) of users, provided such access or dissemination is consistent with or in furtherance of a Lawful Government Purpose and in a manner consistent with applicable law, regulations, and Government-wide policies.

# CUI

## DTRA REASONABLE ACCOMMODATION REQUEST MEDICAL INQUIRY FORM

### Privacy Act Statement

**Authority:** Rehabilitation Act of 1973 (Section 501 and 505); 29 Code of Federal Regulations (CFR) Part 1630; E.O 13163; E.O. 13164, EEOC Policy; and DTRA 5505.3, DTRA Reasonable Accommodation Instruction.

**Purpose(s):** To provide reasonable accommodation(s) for individuals with known physical and mental impairments who have applied for employment or are employees of the DTRA.

**Routine uses:** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: The DOD 'Blanket Routine Uses' apply. The DoD Health Information Privacy Regulation (DoD 6025.18-R) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, also applies to most such health information.

**Disclosure:** Voluntary; however, failure to provide this information may delay or impede your Reasonable Accommodation Request.

1. NAME (Last, First, MI):

2. TELEPHONE NUMBER:

3. DIRECTORATE/ STAFF OFFICE:

4. SUPERVISOR:

### A. QUESTION TO DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY.

For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such impairment. The following questions will determine whether an employee has a disability:

5. DOES THE EMPLOYEE HAVE A PHYSICAL OR MENTAL IMPAIRMENT?

☐ Yes

☐ No

5a. IF YES, WHAT KIND OF IMPAIRMENT?

6. IS THE IMPAIRMENT LONG-TERM OR PERMANENT?

☐ Yes

☐ No

6a. IF NOT PERMANENT, HOW LONG WILL THE IMPAIRMENT LIKELY LAST?

Answer the following questions based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

7. Does the impairment substantially limit a major life activity?

*Note: Does not need to significantly or severely restrict to meet this standard*

☐ Yes

☐ No

7a. If yes, what major life activity(s) is/are affected?

☐ Caring For Self

☐ Walking

☐ Hearing

☐ Lifting

☐ Interacting With Others

☐ Standing

☐ Seeing

☐ Sleeping

☐ Performing Manual Tasks

☐ Reaching

☐ Speaking

☐ Concentrating

☐ Breathing

☐ Thinking

☐ Learning

☐ Reproduction

☐ Working

☐ Toileting

☐ Sitting

☐ Other: (describe)

8. PLEASE PROVIDE AND EXPLANATION (I.E. 100LBS)

9. Does the impairment substantially limit the operation of a major bodily function?

*Note: Does not need to significantly or severely restrict to meet this standard.*

☐ Yes

☐ No

## DTRA REASONABLE ACCOMMODATION REQUEST MEDICAL INQUIRY FORM

### A. QUESTION TO DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY (CONTINUED).

9a. If yes, what bodily function is affected?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Immune             | <input type="checkbox"/> Hemic                         | <input type="checkbox"/> Circulatory     | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Special Sense Organs and Skin | <input type="checkbox"/> Endocrine       |  |
| <input type="checkbox"/> Digestive          | <input type="checkbox"/> Lymphatic                     | <input type="checkbox"/> Reproductive    |  |
| <input type="checkbox"/> Bowel              | <input type="checkbox"/> Neurological                  | <input type="checkbox"/> Musculoskeletal |  |
| <input type="checkbox"/> Bladder            | <input type="checkbox"/> Brain                         | <input type="checkbox"/> Special Sense   |  |
| <input type="checkbox"/> Genitourinary      | <input type="checkbox"/> Respiratory                   | <input type="checkbox"/> Cardiovascular  |  |

### B. QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

10. WHAT LIMITATION(S) IS INTERFERING WITH JOB PERFORMANCE?

11. WHAT JOB FUNCTION(S) IS THE EMPLOYEE HAVING TROUBLE PERFORMING BECAUSE OF THE LIMITATION(S)?

12. HOW DOES THE EMPLOYEE'S LIMITATION(S) INTERFERE WITH HIS/HER ABILITY TO PERFORM THE JOB FUNCTION(S)?

### C. EFFECTIVE ACCOMMODATION OPTIONS.

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship.

13. BASED ON YOUR REVIEW DO YOU HAVE ANY RECOMMENDATIONS REGARDING THE REQUESTED ACCOMMODATION? ☐ Yes ☐ No  
13a. IF SO, WHAT ARE THE

### D. ADDITIONAL COMMENTS:

14. MEDICAL PROFESSIONAL SIGNATURE

15. DATE

***Please insure this form is provided to the Human Resources Office, Reasonable Accommodation Coordinator after it has been signed by a Health Care Provider***