Portland Community College
Medical Inquiry Form in
Response to an Employee Accommodation Request
(To be completed by medical provider)

PCC Employee/ Patient's Name:		
A. Questions to help determine whether an individual has a disability.		
Does the employee have a physical or mental impairment?	Yes ☐	No ☐
If *yes*, what is the impairment? ***(Please provide information on medical diagnosis and date of the most recent evaluation)***		
Is the impairment long-term? Is the impairment permanent?	Yes ☐ Yes ☐	No ☐ No ☐
If *not* permanent, how long will the impairment likely last?		
Please answer the following questions based on the limitations the employee has when his/her condition is in an active state and the limitations the employee would have if no mitigating measures were used. Mitigating measures include medication, medical supplies, equipment, hearing aids, mobility devices, 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.		
Does the impairment substantially limit a major life activity? *Note: Does not need to significantly or severely restrict to meet this standard.*	Yes ☐	No ☐
If *yes*, what major life activity(s) is/are affected? Check all that apply: ☐ Caring For Self ☐ Hearing ☐ Speaking ☐ Concentrating ☐ Breathing ☐ Seeing ☐ Learning ☐ Reproduction ☐ Working ☐ Reaching ☐ Sitting ☐ Interacting with Others ☐ Walking ☐ Thinking ☐ Lifting ☐ Perform Manual Tasks ☐ Standing ☐ Toileting ☐ Sleeping ☐ Other (describe):		
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 ☐
If yes, what bodily function is affected? ☐ Immune ☐ Hemic ☐ Circulatory ☐ Cardiovascular ☐ Digestive ☐ Lymphatic ☐ Endocrine ☐ Normal Cell Growth ☐ Bowel ☐ Neurological ☐ Reproductive ☐ Special Sense Organs and Skin ☐ Bladder ☐ Brain ☐ Musculoskeletal ☐ Other (describe): ☐ Genitourinary ☐ Respiratory ☐ Special Sense		

B. Questions to help determine whether an accommodation is needed.

What are the limitation(s) that interfere with employee's ability to perform job duties?

What job duties is the employee having trouble performing because of the impairment or limitation(s)?

How do the employee's limitation(s) interfere with his/her ability to perform the job duties?

C. Questions to help determine effective accommodation options.

Do you have any suggestions for possible accommodations, to assist with performance of job duties? If so, what are they?

How would your suggestions improve the employee's ability to perform job duties?

D. Comments or additional information in support of request.

E. Medical Certification:

_____/_____/_____

Medical Professional's Signature | Name (please print) | Date

_____/_____

Clinic or Company Name | Phone number

_____/_____/_____/_____

Address | City | State | Zip

Return this form to: Karol Ford, ADA Coordinator at adacoordinator@pcc.edu or Fax to (971) 722-5025.
Mailing Address: PCC Human Resources, P.O. Box 19000, Portland, Oregon 97280.
For questions email adacoordinator@pcc.edu or call 971-722-5869.