

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

<b>PCC Employee/ Patient's Name:</b>																						
<b>A. Questions to help determine whether an individual has a disability.</b>																						
Does the employee have a physical or mental impairment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																				
If yes, what is the impairment?  <i>(Please provide information on medical diagnosis and date of the most recent evaluation)</i>																						
Is the impairment long-term?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																				
Is the impairment permanent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																				
If <i>not</i> 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.																						
<b>Does the impairment substantially limit a major life activity?</b> <i>Note: Does not need to significantly or severely restrict to meet this standard.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>																				
If yes, what major life activity(s) is/are affected? Check all that apply:																						
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Caring For Self</td> <td><input type="checkbox"/> Hearing</td> <td><input type="checkbox"/> Speaking</td> <td><input type="checkbox"/> Concentrating</td> </tr> <tr> <td><input type="checkbox"/> Breathing</td> <td><input type="checkbox"/> Seeing</td> <td><input type="checkbox"/> Learning</td> <td><input type="checkbox"/> Reproduction</td> </tr> <tr> <td><input type="checkbox"/> Working</td> <td><input type="checkbox"/> Reaching</td> <td><input type="checkbox"/> Sitting</td> <td><input type="checkbox"/> Interacting with Others</td> </tr> <tr> <td><input type="checkbox"/> Walking</td> <td><input type="checkbox"/> Thinking</td> <td><input type="checkbox"/> Lifting</td> <td><input type="checkbox"/> Perform Manual Tasks</td> </tr> <tr> <td><input type="checkbox"/> Standing</td> <td><input type="checkbox"/> Toileting</td> <td><input type="checkbox"/> Sleeping</td> <td><input type="checkbox"/> Other (describe):</td> </tr> </table>			<input type="checkbox"/> Caring For Self	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speaking	<input type="checkbox"/> Concentrating	<input type="checkbox"/> Breathing	<input type="checkbox"/> Seeing	<input type="checkbox"/> Learning	<input type="checkbox"/> Reproduction	<input type="checkbox"/> Working	<input type="checkbox"/> Reaching	<input type="checkbox"/> Sitting	<input type="checkbox"/> Interacting with Others	<input type="checkbox"/> Walking	<input type="checkbox"/> Thinking	<input type="checkbox"/> Lifting	<input type="checkbox"/> Perform Manual Tasks	<input type="checkbox"/> Standing	<input type="checkbox"/> Toileting	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Other (describe):
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<b>Does the impairment substantially limit the operation of a major bodily function?</b> <i>Note: Does not need to significantly or severely restrict to meet this standard.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>																				
If yes, what bodily function is affected?																						
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**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:** María Méndez, ADA Coordinator. Mailing Address: PCC Human Resources P.O. Box 19000, Portland, Oregon 97280 or Fax to: (971) 722-5025. For questions call (971) 722-5851 or email: [maria.mendez7@pcc.edu](mailto:maria.mendez7@pcc.edu)