



Medical Information Request Form -Confidential-

Human Resources Complete

Employee Name: _____

Job Title: _____

The employee works a regular schedule of: _____ hrs per shift, or _____ hrs per week

Other Comments:

Treating Healthcare Provider Complete

1. What is the employee's physical or mental health condition?

2. Are you the treating healthcare provider of this health condition? Yes No

3. Identify the major life activities below that are limited due to the health condition(s), the treatment for the health condition, and/or the side effect(s) of medication for the health condition(s) that may influence these major activities. Then, explain any limitations below.

Major Life Activities:

- | | | | | | |
|---|--------------------------------|--------------------------------|--------------------------------|---|--|
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Think | <input type="checkbox"/> Hear | <input type="checkbox"/> Learn | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Caring for Oneself |
| <input type="checkbox"/> Interact with others | <input type="checkbox"/> Sleep | <input type="checkbox"/> Eat | <input type="checkbox"/> Read | <input type="checkbox"/> Communication | <input type="checkbox"/> Other (Please list Below) |
| <input type="checkbox"/> Work | <input type="checkbox"/> Sight | <input type="checkbox"/> Break | <input type="checkbox"/> Speak | <input type="checkbox"/> Major Bodily Functions (Please List Below) | |

Explain:

4. What is the duration of the limitation(s) as indicated in #3 above?
(Please estimate if unknown.)

5. What is the impact on the individual's ability to perform the job based on the job description and/or functional job assessment attached?

6. Please complete the following:

Limitation in the number of hours worked:

Work no more than _____ hours/day

Work no more than _____ hours/week

During Work Hours:

Stand no more than _____ hours

Walk no more than _____ hours

Sit no more than _____ hours

Frequently = 34%-66% of the time - Occasionally = 1%-33% of the time

- Lift up to _____ pounds
Frequently or Occasionally (Circle one.)
- Push/pull/force up to _____ pounds
Frequently or Occasionally (Circle one.)
- Bend, twist, stoop
Frequently or Occasionally (Circle one.)
- Reaching
Frequently or Occasionally (Circle one.)

Office Name of Treating Health Care Provider: _____

Treating Health Care Provider Printed Name: _____

Treating Health Care Practitioner Signature: _____

Date: ____ / ____ / _____

Return Completed Form

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