NJIT ADA INTERACTIVE PROCESS QUESTIONNAIRE

Healthcare Provider : _____

Employee Name : _____

Job Evaluated : _____

Date : _____

Please answer and return the following questionnaire to your patient within the time indicated. The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Thank you for your anticipated cooperation.

***Please email completed form to** **hraccommodations@njit.edu** **.**

IMPORTANT NOTE TO HEALTHCARE PROVIDER: When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

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.

1. **Does this employee have a physical or mental impairment**?

   ◯ **Yes** ◯ **No**

If so, please state the type of impairment: _____

2. **Does this employee's impairment substantially limit any major life activities?**

   ◯ **Yes** ◯ **No**

If so, which major life activities are limited? _____

3. **For each major life activity that is limited by the impairment, please describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity :** _____

_____

4. **What is the duration or expected duration of the employee's impairment?**

_____

_____

5. **Attached is a job description for the employee's position. Can the employee perform all job functions?**

   ◯ **Yes** ◯ **No**

If not which job functions cannot be performed and why? _____

_____

6. **Please describe any reasonable accommodations that would allow this employee to be able to perform those job functions:** _____

_____

7. **If leave is the accommodation, please identify: (a) the duration of the leave; and (b) a return to work date.**

_____

8. **If the employee will require intermittent leave or leave for flare-up conditions, please identify: (a) the frequency of leave anticipated per month; and (b) the amount of day(s) or time off needed for each leave or flare-up.**

_____

_____

9. **Would performing any of the job functions listed result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc.)?**

◯ **Yes** ◯ **No**

If yes, please describe : _____

_____

which job function(s) would pose such a threat:_____

_____

the direct safety or health threat posed:_____

_____

any reasonable accommodation that would eliminate the direct safety or health threat, or reduce it to an acceptable level: _____

_____

Health Provider Signature: _____ **Date:** _____

PRINT NAME: _____

ADDRESS: _____

AFFIX STAMP BELOW