Clear Form

ADA Medical Assessment Form

Forms can be mailed to: Hartford Leave Management
P.O Box 14285
Lexington, KY 40512-4285
Or faxed to: Toll Free Fax Number: (877) 588-4817

This form must be returned no later than: _____

Employee's Name:	Last 4 digits of Social Security Number:
Leave ID:	Date of Birth:
Employer's Name:	
Today's Date:	

The above employee has requested under the Americans with Disabilities Act Amendments Act (ADAAA), as amended, to enable the employee to perform the essential functions of his/her position. The information requested on this form will assist in making a determination regarding the employee's request.

INSTRUCTIONS: The following form must be completed in detail and signed by the employee's medical provider. Please attach additional pages or records as needed. **Do not provide information not related to the employee's ability to perform his/her job duties. Example: Do not identify an impairment if it does not have an impact on employee's ability to perform his/her job duties.**

IMPORTANT NOTICE REGARDING GINA

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 the manifestation of disease or disorder in family members of the individual, 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Please confirm you have examined the employee and are familiar with the employee's medical history. ☐ Yes ☐ No

2. Please confirm you have reviewed the job description or equivalent for the employee.
☐ Yes ☐ No

3. Is the employee released to return to work full time, full duty without the need for restrictions, limitations, or accommodations? ☐ Yes ☐ No

   If yes, please state the employee's full, unrestricted return to work date: _____

IF NO, PLEASE COMPLETE THIS FORM.

4. When can the employee return to work with restrictions or an accommodation? [Additional questions regarding restrictions or accommodations below]. _____

5. ***Existence of impairment.*** Does the employee have a physical or mental impairment(s)?
☐ No ☐ Yes Please list impairment(s):

_____

_____

Note: A physical or mental impairment under the ADA is:

- Any physiological disorder, condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or
- Any mental or psychological disorder, such as an intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
- The disorder or condition is considered:
  - In its active state, even if presently in remission. (Examples: epilepsy, MS, asthma, cancer, bipolar disorder.)
  - Without regard to the effects of mitigating measures such as prostheses, medication, etc., except ordinary eyeglasses.
  - With consideration of the negative effects of treatment such as medication or other measures.

6. Limitations on major life activities. If the answer to #5 is yes, does the employee's impairment substantially limit one or more major life activities? ☐ Yes ☐ No

Note: Whether an impairment substantially limits the ability of an individual to perform a major life activity is determined:

- As compared to most people in the general population; and
- Does not need to prevent, or significantly or severely restrict, the individual from performing a major life activity – the impairment only needs to "substantially limit" the employee's ability to perform the major life activity.

7. ***Limitations on major life activities (cont.).*** If the answer to #5 is yes, which major life activity(s) is/are affected? Check all major life activities that both (a) are affected by the employee's impairment(s) and (b) restrict or limit the employee's ability to perform the employee's job duties.

Major life activities – general life activities:

- ☐ Bending
- ☐ Breathing
- ☐ Caring for self
- ☐ Concentrating
- ☐ Eating
- ☐ Hearing
- ☐ Interacting with others
- ☐ Learning
- ☐ Lifting
- ☐ Performing manual tasks
- ☐ Reading
- ☐ Reaching
- ☐ Seeing
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Walking
- ☐ Working
- ☐ Other(s) (describe)

_____

_____

Major life activities – operation of major bodily functions:

- ☐ Bladder
- ☐ Bowels
- ☐ Brain
- ☐ Cardiovascular
- ☐ Circulatory
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinary
- ☐ Hemic
- ☐ Immune
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Normal cell growth
- ☐ Operation of an organ
- ☐ Reproductive
- ☐ Respiratory
- ☐ Sensory organs & skin
- ☐ Other(s) (describe)

_____

_____

8. ***Commencement of impairment(s).*** For the impairments identified above, when did the employee's impairment(s) commence? If there is more than one impairment, please specify the start date for each:

_____

_____

_____

9. ***Performance of essential job functions.*** Does the employee's impairment(s) limit his/her ability to perform the essential functions of the employee's position (as defined in the job description) without any accommodation? ☐ Yes ☐ No

   If the answer is yes, please:

   a. Identify which essential function(s) the employee is unable to perform without an accommodation:

_____

_____

_____

b. Describe the manner in which the employee's ability to perform each essential function is limited:

_____

_____

_____

10. ***Accommodation(s)*. Please describe:**

Note: Reasonable accommodations may include such things as a modified work schedule, provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee's position, and extended leave of absence to allow time for recovery, therapy, training, or other disability-related needs.

a. This employee is specifically requesting a leave of absence as an accommodation. Will a leave of absence assist the employee to return to work? ☐ Yes ☐ No

b. How will leave assist the employee in returning to work?

_____

_____

_____

c. *Duration*. What are the dates during which you anticipate the employee will need the leave of absence?

Continuous leave starting on _____ through _____

Reduced schedule leave starting on _____ through _____ with an anticipated schedule of: ____ hour(s) per day; ____ days per week

Intermittent leave starting on _____ through _____ with an anticipated frequency and duration of absences for (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: ____ times per ____ week(s) ____ months(s)

Duration: ____ hours or ____ days(s) per episode

Note: You must provide your best medical judgment, based on current information, as to the the length of time the employee will need an accommodation to perform his/her essential job functions.

11. Is there another accommodation(s) instead of a leave of absence that will enable the employee to perform the essential job functions? ☐ Yes ☐ No

If so please describe:

_____

_____

_____

a. How will the accommodation(s) assist the employee in performing the essential job functions.

_____

_____

_____

_____

b. Duration. For how long do you anticipate the employee will need the identified accommodation(s) to perform the essential job functions?

Note: You must provide your best medical judgment, based on current information, as to the length of time the employee will need an accommodation to perform his/her essential job functions.

(check one) ☐ days ☐ weeks ☐ months ☐ years or ☐ permanent

Comments:

_____

_____

12. ***Additional information.*** Are you aware of any other information that The Hartford should consider in assessing whether the employee can perform the essential job functions with or without accommodation? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Provider Name (print): _____

Provider Signature: _____

Provider Practice/Specialty: _____

Provider Phone Number: ( ) _____

Provider Address: _____

Date: _____