

BALTIMORE COUNTY PUBLIC SCHOOLS

**Integrated Disability Management
Office of Risk Management
Timonium Office
Office Phone: 410-887-4133
Fax: 410- 308-4720 (confidential)**

**EEO Office
1946 N Greenspring Drive
Timonium, MD 21093
Office Phone: 410-887-8937
Fax: 410-252-6404 (confidential)**

MEDICAL INQUIRY FORM

Employee Name: _____ Job Title: _____

Diagnosis: _____

Complications: _____ Prognosis: _____

Please provide an update on this patient's medical status. You can return the form by fax to the office circled above. Thank you for your prompt response.

Does the employee have a physical or mental impairment? Yes No

What is the impairment? _____ Is the impairment long-term or permanent? Yes No

Does the impairment affect a major life activity? Yes No

Is the employee substantially limited in one or more major activities? Yes No

If *yes*, what major life activity(s) is/are affected? **(see list on back)**

What job function(s) is the employee having trouble performing because of the limitation(s)?

Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

Please mark below the patient's current status for **Return to Work (RTW)**:

If there are any restrictions which could allow the employee to work transitional duty or to be provided with a reasonable accommodation, Under the Americans with Disabilities Act (ADA) (please complete page 2)

Definition of disability: A person has a disability under the ADA if the person has a mental or physical impairment that substantially limits one or more major life activities.

Transitional duty: Temporary transitional duty assignments designed to assist employees with the return to their current position are available. These temporary assignments may involve assisting other professionals or employees in duties or tasks that are consistent with the employee's training and skills.

Return to **Part-time Transitional duty**: Date: _____ Return to **Full-time Transitional duty**: Date: _____
***(complete page 2)** ***(complete page 2)**

Has this patient reached **Maximum Medical Improvement (MMI)**? Yes No

**Both sides must be completed (if applicable)
(Physician's Signature Required on Page 2)**

1. **If released to return to work, the employee:**

- a. In an 8-hour workday, the employee can **STAND/WALK:**
 not at all 1-3 hours 3-5 hours 5-8 hours no restrictions
- b. In an 8-hour workday, the employee can **SIT:**
 not at all 1-3 hours 3-5 hours 5-8 hours no restrictions
- c. In an 8-hour workday, the employee can **DRIVE:** (If a requirement of job duties)
 not at all 1-3 hours 3-5 hours 5-8 hours no restrictions
- d. In an 8-hour workday, the employee can **LIFT/CARRY:** (Occasionally = 1% - 33% Frequently = 34% to 66%)

	<u>No restriction</u>		<u>Frequently</u> 34% - 66%		<u>Occasionally</u> 1% - 33%		<u>Not at all</u>	
	<u>LIFT</u>	<u>CARRY</u>	<u>LIFT</u>	<u>CARRY</u>	<u>LIFT</u>	<u>CARRY</u>	<u>LIFT</u>	<u>CARRY</u>
0 - 10 lbs								
11 - 20 lbs								
21 - 50 lbs								
51+ lbs.								

- e. In an 8 hour workday, the employee is able to: (Occasionally = 1% - 33% Frequently = 34% to 66%)

	<u>No restriction</u>	<u>Frequently</u> 34% - 66%	<u>Occasionally</u> 1% - 33%	<u>Not at all</u>
bend				
Squat				
Climb				
Kneel				
Twist				
Push/pull				
Reach				
Stand				
Care for self				
Learning/thinking				
Sleeping				
Speaking/hearing				
Concentrating				
reading				

2. Employee can use hands for Gross grasping: Yes No Fine manipulation: Yes No
3. Employee is able to reach above shoulder level: Yes No
4. RESTRICTIONS NOT LISTED ABOVE: _____

Signature of Physician: _____ **Date** _____

Physician's Name (Please print): _____

Phone No. _____ **Fax No.** _____ **Email:** _____