INTERACTIVE PROCESS QUESTIONNAIRE

To:

Name of Employee:

Job Evaluated:

Please answer and return the following questionnaire to your patient at your earliest convenience. 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.

IMPORTANT NOTE TO HEALTH CARE 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.

1. Does the Employee have a physical or mental impairment?
   Yes ◯ No ◯

   If so, please state the type of impairment:

2. Does the Employee's impairment substantially limit any major life activities?
   Yes ◯ No ◯

   If so, which major life activity or 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 Employee's impairment?

5. Attached is a job description for the position. Please review the job description and assess whether Employee can perform all job functions:

   Yes ◯ No ◯

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

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

7. If medical leave is one of the possible accommodations listed above, please provide an estimated duration for the leave:

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8. Would performing any of the job functions listed result in a direct safety or health threat to this employee or to other people (e.g., coworkers, 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 accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level:

_____ _____ _____

Signature Title Date

Printed Name and Address: