U.S. Department of State

MEDICAL QUESTIONNAIRE FOR ASSESSMENT OF DISABILITY/REASONABLE ACCOMMODATION

For the Employee

(a) Release of Information - Please sign and date the authorization printed below for release of information by your physician to the Department of State.

"I hereby authorize my physician to provide the information requested below to the Department of State and to provide any further requested information verbally or in writing regarding my medical or mental health condition(s) to the Bureau of Medical Services and the Bureau of Global Talent Management, U.S. Department of State. The information provided will be used by the Department of State for the purposes outlined in the Office of Personnel Management regulations on medical examinations contained at 5 C.F.R. Part 339."

☐ By checking this box, I, _____ , certify that I am the individual submitting this document.

Date *(mm-dd-yyyy)*

_____ _____
Employee's Name *(printed)* Employee ID Number

_____
Home Address

_____ _____ _____
City State ZIP Code

_____ _____ _____
Work Phone Home Phone Email Address

(b) **Employee Statement** - On a separate sheet of paper, explain the specific limitations in your job duties for which you are requesting an accomodation. If applicable state the specific work changes or accommodation you are requesting and, if known, the medical reason for your request. (Note: This questionnaire will not be reviewed by the Bureau of Medical Services without the Employee Statement.) Submit a copy of your Employee Statement to GTA/OAA/DRAD. You may e-mail a scanned pdf attachment to ReasonableAccommodations@state.gov or fax to 202-663-3972.

(c) Have your physician sign this form and submit the information requested below.

(d) Work Requirements Statement - Submit your Work Requirements Statement with this form to your physician so that your physician may make any recommendations with full knowledge of your work requirements.

For the Doctor

(The information requested below is for the use of the Department of State (*DOS*) and will be reviewed by DOS medical professionals and select staff from GTA/OAA/DRAD who routinely review the requested information.)

Please provide the following information about this patient's medical condition/impairment as it pertains to his/her ability to work.
(a) Diagnosis, history, objective findings, and current status of the medical (including psychological) condition. Prognosis, including plans for future treatment and an estimate of the date of full or partial recovery. Basically describe the nature, severity, and duration of this patient's medical condition/impairment.

(b) Current Medications and/or other medical treatments (e.g., PT, counseling, dialysis).

(c) To comply with the Genetic Information Nondiscrimination Act of 2008 (*GINA*), do NOT provide information about genetic tests, as defined in 29 C.F.R. 1635.3(f), genetic services, as defined in 29 C.F.R. 1635.3(e), or the manifestation of disease or disorder in the employee's family members 29 C.F.R. 1635.3(b). GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of individual, except as specifically allowed by law. '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.

(d) Describe which activities (both on and off the job) the medical condition limits and the extent to which the condition limits the ability to perform these activities.

(e) Review the Work Requirements Statement provided by your patient and attach here. Considering your patient's medical condition/impairment, make a clinical assessment of the injury, hazard, risk or other consequence to your patient or others that would arise if s/he were to work without the requested accommodation or work change. If a work change is requested by the employee and you do not believe the medical condition warrants such a change, please state: "No work change necessary."

(f) If a work change or accommodation is needed, please specify what change or accommodation is needed and substantiate why. *(How will this accommodation or work change allow your patient to fulfill his/her work requirements safely without harm to himself or others?*)

(g) Please estimate the duration (or frequency) this work place accommodation will be needed. If the work change will be for a limited amount of time, when and how will you reassess the patient?

(h) If the work change or accommodation you specify is obtained by your patient, what (if any) other medical limitations would preclude your patient from being able to perform the attached work requirements?

(i) Other Comments

(j) Please sign and date this form. You may respond on your letterhead with your name, address and telephone number. If you have any questions, please call MED Domestic Programs at 202-663-2508. This form should be e-mailed as a scanned pdf to MedDP@state.gov or sent to medically secure fax 202-663-3673.

Attn.: Domestic Programs
Bureau of Medical Services
2401 E Street N.W. SA-1
Washington, DC 20522-0101

Email MedDP@state.gov
Fax 202-663-3673 (medically secure)
Phone 202-663-2508

☐ By checking this box, I, _____ , certify that I am the individual submitting this document.

Date *(mm-dd-yyyy)*

_____ _____
Physician's Name Printed or Typed Name and Degree Phone

_____
Address

_____ _____ _____
City State ZIP Code

Attachment: Work Requirements

Privacy Act Statement

AUTHORITIES: The information is sought pursuant to 5 C.F.R. Part 339, Administrative Personnel, Medical Qualifications Determination.

PURPOSE: The purpose for gathering this information is to review the medical justification for reasonable accommodations in compliance with the Rehabilitation Act of 1973 and Americans with Disabilities Amendment Act as Amended.

ROUTINE USES: Information collected on this form will not be shared outside the Department of State.

DISCLOSURE: Providing this information is voluntary. However, failure to provide the information requested on this form may result in the applicant's inability to receive the requested accommodation(s).