Clear Form

ADA Medical Assessment Form

Forms can be mailed to: Hartford Leave Management
P.O Box 14869
Lexington, KY 40512-4869

Or faxed to: Toll Free Fax Number: (833) 357-5153

THE HARTFORD

This form must be returned no later than: _____

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

The above employee has requested a reasonable accommodation under the Americans with Disabilities Act ("ADA"). The Hartford has been engaged by the Employer to obtain the information requested on this form to assist Employer in evaluating the employee's reasonable accommodation 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. Type of accommodation?
   ☐ Leave of Absence
   ☐ Workplace Accomodation (Not Leave of Absence)

Note: Reasonable accommodations are any changes in the employee's terms or conditions of employment, or in the way in which the employee's job is ordinarily performed, that enables the employee to perform the essential functions of employee's position. Reasonable accommodations may include, but are not limited to 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

4. ***Existence of impairment.*** (Do NOT COMPLETE this question if the employee works in the State of California. Please skip ahead to question 8)
   Is the employee's work restrictions or need for reasonable accommodation because of 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.

5. Limitations on major life activities. If the answer to #4 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.

6. ***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)

_____

_____

7. ***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:

_____

_____

_____

8. ***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:

_____

_____

_____

Leave as an Accommodation

9. If the employee is specifically requesting a leave of absence as an accommodation.

a. 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. Please check the box that best describes the amount of time you expect the employee to be absent from work.

☐ **Indefinite** - No return to work date can be determined at this time.

☐ **Definite** - Please include date on which employee is realistically expected to return to work (not date of next appt with healthcare provider)

Return to Work date: _____

d. *Duration*. What are the dates, type of leave, and if applicable, the frequency and duration, you anticipate the employee will need for 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):

Please estimate the absences needed for flare-ups of condition:

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

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

Please estimate the absences needed for office visits for condition:

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

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

Note: Please 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.

Workplace Accommodation (Not Leave of Absence)

10. Will an accommodations(s) 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?

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

Note: Please 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.

Comments:

11. ***Additional information.*** Are you aware of any other information that should be considered in assessing whether the employee can perform the essential job functions with or without accommodation. ☐ Yes ☐ No

If yes, please describe:

12. COVID-19 Vaccine Exemption (Please complete if employee is requesting to be excused from the employer's COVID-19 Vaccination requirements due to a medical condition or contraindication)

a. Please confirm if you have recommended the employee not receive the COVID-19 vaccine due to their medical condition? ☐ Yes ☐ No

If yes, do you anticipate the employee's medical condition will improve so they will be able to receive the COVID-19 vaccine at a later date? ☐ Yes ☐ No
If Yes, approximately what date?

b. Does the employee's medical condition preclude them from regular COVID-19 procedures below:

Testing: ☐ Yes ☐ No Wearing face coverings: ☐ Yes ☐ No

Provider Name (print): _____

Provider Signature: _____

Provider Practice/Specialty: _____

Provider Phone Number: ( ) _____

Provider Address: _____

Date: _____