PHYSICIAN QUESTIONNAIRE

This questionnaire is designed to assist in complying in good faith with the requirements of applicable laws, rules and regulations relating to accommodating employees with disabilities. Your answers will assist our efforts to determine if our employee meets the criteria necessary to be considered a person with a disability and if so, assist in identifying potential reasonable accommodation(s) to a known disability. Please sign and return the completed form and direct any questions regarding it to:

Vice President of Human Resources
Walla Walla Community College
500 Tausick Way
Walla Walla, WA 99362
Phone: (509) 527-4382
Fax: (509) 527-4313

Enclosed please find an "Authorization to Release Medical Information" form signed by the employee, along with a Position Description Form.

Employee Name: _____

Job Title: _____

This section to be completed by the physician:

1. What is your area of medical expertise?

2. Does the employee have a current impairment? Yes _____ No _____

3. What is the diagnosis?

4. Please discuss the evidence of this impairment. Major life activities include those activities that are of central importance to most people's daily lives, including but not limited to walking, speaking, breathing, hearing, eating, reading, sleeping, caring for oneself, interacting with others, seeing, thinking, working.

5. Is a major life activity affected by the impairment? Yes _____ No _____

   a. If yes, what is the major life activity?

6. A person is substantially limited in a major life activity if the person is unable to perform, or is significantly restricted as to the condition, manner, or duration under which they perform the activity as compared to the average person. Does the impairment substantially limit the major life activity? Yes _____ No _____

7. Please discuss what the employee cannot do, as well as what they are able to do.

   Note: *If the employee takes medication, uses corrective devices, or is otherwise compensated for the impairment, please discuss their abilities as medicated or otherwise compensated*.

8. For the impairment(s) described above, please indicate how long the impairment is likely to persist, and what events may affect the length of time it is likely to persist.

9. The employee has to be able to perform the the essential job functions as outlined in his/her job description (copy attached): Can the employee perform the essential functions of the position, either with or without a reasonable accommodation?

   Yes _____ No _____

   a. If yes, does the employee need a reasonable accommodation to perform the essential functions of his/her position?

      Yes _____ No _____

10. Please identify, in as specific terms as you can, the limitations caused by or associated with the above-referenced impairment that affect this employee's ability to perform the essential functions of his/her job.

11. For the limitation(s) described above, please describe the way or ways that you believe would be effective in reducing the effects of those limitations.

12. Please provide whatever other information you believe would assist this employer in making a decision regarding this employee's ability to perform the essential functions of his/her assigned job.

Physician Certification:

I declare that, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

_____
Physician Name

_____
Physician Signature

_____
Date

Physician Contact Information:

Office Address: _____

_____

Phone: _____

Fax: _____