

SECTION 2:		Medical Professional Information (To be completed by Physician, Psychologist, Diagnostician or other medical professional)			
Employee Full Name: First, Last Name (Please print)			Employee Address		
<p>This is to advise that the employee identified has requested reasonable accommodation(s) to perform essential job functions at New Mexico State University. We would appreciate receiving sufficient information to determine if the employee is eligible to receive the requested accommodation(s) in accordance with state and federal laws.</p> <p>[See attached job description or Essential Job Functions Questionnaire]</p>					
1. Diagnosis of condition or brief description of disability (For mental disability, reference diagnosis to DSM-IV)					
2. When was the employee initially seen?				Currently under your care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Prognosis: The condition is		<input type="checkbox"/> TEMPORARY		<input type="checkbox"/> PERMANENT	
		If temporary, define term			
If medication is required, is condition currently:					
<input type="checkbox"/> Under control with medication			<input type="checkbox"/> Not under control with medication		
If condition is not under control with medication, what are the symptoms?					
4. If the employee is taking medication, are there any side effects from the medication which might affect work performance?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:					
5. What major life activities are impacted?					
<input type="checkbox"/> Bending	<input type="checkbox"/> Breathing	<input type="checkbox"/> Caring for self	<input type="checkbox"/> Communicating	<input type="checkbox"/> Concentrating	
<input type="checkbox"/> Eating	<input type="checkbox"/> Hearing	<input type="checkbox"/> Interacting with others	<input type="checkbox"/> Learning	<input type="checkbox"/> Lifting	<input type="checkbox"/> Reaching
<input type="checkbox"/> Performing manual tasks		<input type="checkbox"/> Reading	<input type="checkbox"/> Seeing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Sleeping
<input type="checkbox"/> Speaking	<input type="checkbox"/> Standing	<input type="checkbox"/> Thinking	<input type="checkbox"/> Toileting	<input type="checkbox"/> Walking	<input type="checkbox"/> Working
Include Major Bodily Functions:					
<input type="checkbox"/> Bladder	<input type="checkbox"/> Bowel	<input type="checkbox"/> Brain	<input type="checkbox"/> Circulatory	<input type="checkbox"/> Digestive	<input type="checkbox"/> Endocrine
<input type="checkbox"/> Functions of the immune system			<input type="checkbox"/> Neurological	<input type="checkbox"/> Normal cell growth	
<input type="checkbox"/> Reproductive	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Other			
6. Can the employee perform the essential functions of the job without threat to health/safety to:					
a) Self	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, please explain		
b) Others	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, please explain		

7. Is the employee currently able to perform the essential job functions identified in the attached job description or Essential Job Function Questionnaire (or list of duties)?			
With accommodation(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, identify which function(s) and why:	
Without accommodation(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, identify which functions(s) and why:	
8. Does the condition or treatment prevent the employee from meeting the full attendance requirements of the job?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe frequency and duration:			
9. What are typical accommodations for this type of condition? (i.e., rest breaks, lifting, driving, modifying equipment, lighting, etc.)			
10. Is restructuring of work hours needed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
11. For what period of time are reasonable accommodations needed?			
Weeks:		Months:	
Years:		Permanent:	
12. Special instructions for handling emergencies			
<p>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 an individual's family medical history, the results of an individual's or family member 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.</p>			
I certify that the information provided above is true and correct to the best of my knowledge.			
Medical Professional Signature:			Date:
Print Name		Degree, specialty, license number	
Address	City	State	Zip
Office Telephone :		Fax Telephone:	
INSTRUCTIONS FOR MEDICAL PROFESSIONAL: Please mail to: New Mexico State University, Human Resource Service, MSC 3 HRS, P.O. Box 30001, Las Cruces, NM 88003-8001, or Fax to: (575) 646-2806 or Email to Mari Longpre at mlongpre@nmsu.edu			