OHR OCCUPATIONAL MEDICAL SERVICES (OMS)
REASONABLE ACCOMMODATION REQUEST FORM

This form is to be completed when requesting an accommodation or modification to a prior accommodation under the American's with Disabilities Act (ADA). Your Health Care Provider will be required to complete the ADA Medical Questionnaire which will be used to assist the County Employee Medical Examiner in evaluating your medical condition.

Please return this form via e-mail, fax, *or* mail: dpm@montgomerycountymd.gov (email);

240-777-5186 (fax); OR mail to -- Disability Program Manager, Occupational Medical Services, 27 Courthouse Sq. #180, Rockville, MD 20850

PART I: REQUESTED BY

Name:_____ Telephone: _____

Department:_____ Position: _____

Supervisor:_____ Email: _____

PART II: ACCOMMODATION BEING REQUESTED:

_____

_____

NOTE: The ADA does not require that a specific or requested accommodation be granted but rather that an appropriate reasonable accommodation be made to a qualified individual with a disability. The County will make all efforts to reasonably accommodate the employee in his/her current position before exploring alternative placement.

Signature: _____ Date: _____

PART III: TO BE COMPETED BY OMS:

Date request received: _____
Date of Intake Interview Conducted by Disability Program Manager (DPM): _____
Date medical information received: _____
If you are a MCGEO collective bargaining unit employee, do you want the union to receive a copy of this request? ☐ Yes ☐ No

PART IV: **TO BE COMPLETED BY SUPERVISOR**

Department is able to provide accommodation: ☐ Yes ☐ No

If no, please provide information as to why accommodation cannot be granted.

Suggested Alternative Accommodation:

_____

_____

_____

Supervisor Signature:_____ Date:_____

Department is responsible for accommodations under $500.00. OHR will share expenses on accommodations greater than $500.00.

MONTGOMERY COUNTY OCCUPATIONAL MEDICAL SERVICES ADA MEDICAL QUESTIONAIRE

The Americans with Disabilities Act (ADA) of 1990, requires employers to make reasonable accommodations for qualified individuals with a disability. According to the ADA, an individual with a disability is one who:

- Has a physical or mental impairment that substantially limits a major life activity
- Has a record of a substantially limiting physical or mental impairment
- Is regarded as having a substantially limiting physical or mental impairment

---

(Physicians, please answer all questions in detail. This information will be reviewed and evaluated by the Employee Medical Examiner in determining your patient's request to obtain reasonable accommodation in the workplace.

Please return this form via e-mail, fax, *or* mail: dpm@montgomerycountymd.gov (e-mail);

240-777-5186 (fax); OR mail to -- Disability Program Manager, Occupational Medical Services, 27 Courthouse Sq. #180, Rockville, MD 20850

Please note that this form will be kept confidential and placed in the employee's medical record.)

Patient Name: _____ Job Title: _____

1. ADA covered medical condition and date of onset

_____
_____
_____
_____

2. Accommodation being requested

_____
_____
_____
_____

3. Please indicate whether medical condition is:

☐ Temporary

☐ Long-term

☐ Unknown

4. Describe how the condition limits any major life activity. Discuss what the patient is able to do and what the patient is not able to do regarding workplace duties and responsibilities. (Examples of major life activities: walking, talking, seeing, learning, breathing, performing manual tasks, thinking, concentrating, sleeping, working)

_____
_____
_____
_____

5. Does the patients medical condition preclude him/her from performing any of the essential job functions as described by the attached job description? If so, please describe in detail the job tasks that this employee is restricted from performing.

_____
_____
_____
_____

6. Does the patients' medical condition preclude the patient from an assignment in any particular work environment? If so, please explain.

_____
_____
_____
_____

ADDITIONAL COMMENTS:

_____
_____
_____
_____

_____ _____
Health Care Provider Signature and title Date

_____ _____
Health Care Provider/Printed Name Telephone Number