Little Rock School District
HUMAN RESOURCES DEPARTMENT

LITTLE ROCK SCHOOL DISTRICT INTERACTIVE PROCESS QUESTIONNAIRE

To Healthcare provider: ____

Name of Employee: ____

Job Evaluated: ____

Date Needed: ____

A request for a reasonable accommodation has been made by our employee. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer and return the following questionnaire to your patient within the time indicated. The questionnaire format is a guide and we would appreciate a full and complete response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Thank you for your anticipated cooperation.

IMPORTANT NOTE TO HEALTHCARE PROVIDER: When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

1. Does this employee have a physical or mental impairment?

   Yes No

   If so, please state the type of impairment:

   ____
   ____
   ____
   ____
   ____
   ____

2. Does this employee's impairment substantially limit any major life activities?

   Yes No

   If so, which major life activities are substantially limited?

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   ____
   ____
   ____
   ____

3. For each major life activity that is substantially limited by the impairment, please describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way in which an average person in the general population can perform that activity:

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____
____

4. What is the duration or expected duration of the employee's impairment(s)?

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____
____
____

5. Attached is a job description for the employee's position. Can the employee perform all job functions?

Yes No

If not, which job functions cannot be performed and why?

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____
____
____

6. What limitation(s) is/are interfering with the employee's job performance, and how does it interfere with the employee's ability to perform the job function(s)?

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____

7. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

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____
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____

8. Please describe all reasonable accommodations that would allow this employee to be able to perform those job functions:

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____
____
____
____

If medical leave is one of the possible accommodations listed above, please provide an estimated duration for the leave from today's date:

____
____

9. How would your suggestions improve the employee's job performance?

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____
____
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____

10. Would performing any of the job functions listed result in a direct safety or health threat to this employee or other people (co-workers, members of the general public, etc.)?

Yes No

If yes, please describe:

Which job function(s) would pose such a threat?

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____
____
____
____

What is the direct safety or health threat posed?

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____
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Please describe all reasonable accommodations that would eliminate the direct safety or health threat, or reduce it to an acceptable level:

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11. How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?

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Any additional comments or suggestions:

____
____
____
____
____

Health Care Provider's name: (print)____
Health Care Provider's signature: ____
Name of business: ____
Type of practice/Medical specialty: ____
Health Care Provider's business address: ____
____
Telephone: __________________ Fax: ________________Email: _________________________

I authorize the release of necessary confidential medical information regarding my disability to the relevant administrators as deemed necessary by the Human Resources Director of the Little Rock School District.

Employee Signature: ___________________________________ Date: __________________________

Please return completed form to:
Jordan Eason/HR Director of Employee Relations and Benefits Administration
810 W. Markham
Little Rock, AR 72201
jordan.eason@lrsd.org
Office: 501-447-1104 / Fax: 501-447-1162