



Prudential

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: 877-367-7781 Fax: 877-889-4885

Accommodation Medical Inquiry Form

Your employer has asked Prudential to provide administrative support with employees who have requested an accommodation. Your employer is entitled to copies of all forms and information used by Prudential as part of our administrative support of your employer's accommodation program.

Instructions for completing the Accommodation Medical Inquiry Form

Your employer is required to extend reasonable accommodations to employees with a qualified disability to help perform essential job functions. Examples of accommodations include assistive equipment (i.e., sit-stand workstation), job-restructuring, modified work schedules and leaves of absence.

Employee — Please complete and sign sections 1 and 2. Please have your Health Care or Rehabilitation Professional* complete sections 3 through 6.

Health Care or Rehabilitation Professional* — Please complete sections 3 through 6. If you need additional spaces, please feel free to attach additional pages.

**The appropriate professional in any particular situation will depend on the disability and the type of functional limitation it imposes. Appropriate professionals include, but are not limited to, doctors (including psychiatrists), psychologists, nurses, physical therapists, occupational therapists, speech therapists, vocational rehabilitation specialists, and licensed mental health professionals.*

The Employee is responsible for the completion of this form without expense to Prudential.

1	First Name 	MI 	Last Name 	Claim Number
	Date of Birth (MM DD YYYY) 	Gender ☐ Female ☐ Male		
	Employer's Name 		Control Number 	

By the signature below, I give permission to my health care provider to clarify information regarding the clinical reason for me to take time from work as described within this document. I understand that the required information, if not provided by the due date, may result in my leave not being approved or other action by my employer. This information will be directed to Prudential.

X

Employee Signature (Explain relationship if other than employee.) Date Signed (MM DD YYYY)

2	Optional Authorization
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Employee's authorization allowing Prudential to provide disability claim information, including medical, to your employer. While you are not obligated under the law to sign the following authorization, the ability to use information from any insured disability file we may have for you may help process this accommodation request more quickly and may avoid the need to obtain new information already in our insured disability claim file to help process your request for accommodation.

Upon presentation of the original or photocopy of this signed authorization, I authorize the Prudential Insurance Company of America (Prudential) to provide to my employer or its authorized agents, vendors or other representatives information Prudential has obtained in connection with this Request for accommodation, concerning any health care, or treatment provided, including any information from my disability claim file used in evaluating an accommodation. This includes any health information relating to my request for an accommodation, including but not limited to that concerning Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases as well as information on the treatment of mental illness and the use of alcohol, drugs and tobacco but excludes psychotherapy notes. I also authorize Prudential to release information concerning approval or denial of this claim for leave.

I understand that such information will be used by my employer or its authorized agents, vendors or other representatives for the purpose of administering, auditing or otherwise reviewing employee benefits. I further understand that if I choose not to sign this authorization, the processing of my Request for Accommodation may be delayed as Prudential may need to make a new request for information from me or my health care provider for information that is already in Prudential's insured disability claim file."

This additional authorization is valid and may be used for no longer than 24 months after the date it is signed, unless Prudential receives written notice of revocation of this authorization. I agree that a photocopy of this form will be valid as the original.

X

Employee Signature (indicate how related if signed by other than employee.) Date Signed (MM DD YYYY)





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MI

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Last Name

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Claim Number

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3 To be completed by Employee's Health Care or Rehabilitation Professional

Questions to help determine whether an employee has a disability.

For reasonable accommodation an employee has a disability if he or she has a mental or physical impairment that substantially limits one or more major life activities or a record of such an impairment or has a known limitation due to pregnancy, childbirth or related medical condition. The following questions may help determine whether an employee has a disability:

Does the employee have an impairment as described above? ☐ Yes ☐ No

If yes, what is the impairment? *Note: Actual diagnosis information is not required.*

Answer the following question based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population? ☐ Yes ☐ No

If yes, what major life activity(s) is/are affected? *Please indicate all that apply.*

- | | | | |
|---|--|-----------------------------------|-----------------------------------|
| ☐ Bending | ☐ Hearing | ☐ Reaching | ☐ Speaking |
| ☐ Breathing | ☐ Interacting With Others | ☐ Reading | ☐ Standing |
| ☐ Caring For Self | ☐ Learning | ☐ Seeing | ☐ Thinking |
| ☐ Concentrating | ☐ Lifting | ☐ Sitting | ☐ Walking |
| ☐ Eating | ☐ Performing Manual Tasks | ☐ Sleeping | ☐ Working |
| ☐ Other (describe) | | | |





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Claim Number

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To be completed by Employee's Health Care or Rehabilitation Professional (cont'd)

If yes, what major bodily functions is/are affected? *Please indicate all that apply.*

- | | | | |
|---|---|--|--|
| ☐ Bladder | ☐ Digestive | ☐ Lymphatic | ☐ Reproductive |
| ☐ Bowel | ☐ Endocrine | ☐ Musculoskeletal | ☐ Respiratory |
| ☐ Brain | ☐ Genitourinary | ☐ Neurological | ☐ Special Sense Organs & Skin |
| ☐ Cardiovascular | ☐ Blood Disorder | ☐ Normal Cell Growth | |
| ☐ Circulatory | ☐ Immune | ☐ Operation of an Organ | |
| ☐ Other (describe) | | | |

4

To be completed by Employee's Health Care or Rehabilitation Professional

Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed:

What limitation(s) is interfering with job performance or accessing a benefit of employment? How long is each limitation expected to last? For example, cannot stand for more than 2 hours at a time. This limitation is expected to last 4 months.

What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s) and how?





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5 To be completed by Employee's Health Care or Rehabilitation Professional

Absence From Work Details

Please list only dates/times it is medically necessary for the employee to be absent from work due to this medical condition. The employee's medical history and your knowledge of the condition should be used to provide an estimated absence need. If the end date is unknown, provide the next office visit for reevaluation.

A. Which of the following best describes the absence pattern? (check all that apply)

☐ Single Continuous Absence

Start Date (MM DD YYYY)

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End Date (MM DD YYYY)

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☐ Intermittent

☐ Foreseeable (e.g., appointments, therapy)

☐ Unforeseeable (e.g., Flare-Ups)

☐ Both Foreseeable and Unforeseeable

Provide an estimate of the frequency and the length of related incapacity or scheduled appointments that the employee may have.

FREQUENCY: ____ Times per (check only 1) ☐ week, or ☐ month, or ☐ year

LENGTH: ____ minute(s), ____ hour(s) or ____ full day(s) per episode

REMINDER: Include necessary time for travel.

Example:

FREQUENCY: **3** Times per ☐ week, or ☒ month, or ☐ year (check only 1)

LENGTH: ____ minute(s), **2** hour(s) or ____ full day(s) per episode

For approximately how long will the employee need the "time away from work" outlined above? An estimate must be provided.

Start Date (MM DD YYYY)

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End Date (MM DD YYYY)

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☐ Reduced Schedule

Estimate the reduced work schedule the employee needs, if any:

Start date (MM DD YYYY)

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End date (MM DD YYYY)

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Hour(s) per day _____

Day(s) per week _____





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To be completed by Employee's Health Care or Rehabilitation Professional (cont'd)

B. Please provide details regarding the employee's return to work.

Estimated Return To Work Date (MM DD YYYY)

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☐ Full Time ☐ Part Time ☐ With Work Limitations (functions lost)

Describe the return to work plan, and provide any corresponding limitations.

C. Next office visit date, if applicable (MM DD YYYY)

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6 To be completed by Employee's Health Care or Rehabilitation Professional Health Care or Rehabilitation Professional Information

First Name	Last Name	
Professional's Area of Specialty (i.e., physician, therapist, specialty) 		
Office Phone Number	Office Fax Number	
Office Address	Suite	
City	State	ZIP Code

Please Read

GINA Disclaimer: 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, 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'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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

The statements made by me on this form are true and complete.

X

Treating Professional

Date Signed (MM DD YYYY)

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