



INTERACTIVE PROCESS QUESTIONNAIRE
STATE OF NORTH DAKOTA
SFN 59517 (4-2010)

Please Print

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| Employee/Patient Name | Job Title of Employee |
| Physician/Health Care Provider Name | Title of Physical/Health Care Provider |
| Physician Address | |
| Instructions for the physician/health care provider: Please answer and return the following questionnaire to your patient by _____. The questionnaire format is a guide, and we would appreciate a response to every question. We need your complete medical opinion, so feel free to include a more detailed narrative response to any and all questions. Important: When answering these questions, 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 the patient/employee have a physical or mental impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state the type of impairment. | |
| 2. Does the impairment substantially limit major life activities? Some examples of major life activities include, but are not limited to: seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, caring for oneself, performing manual tasks, sitting, reaching, and interacting with others. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which major life activity or activities are limited? | |
| 3. For each major life activity that is limited by the impairment, describe how patient/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. | |
| 4. What is the duration or expected duration of patient/employee's impairment? | |

5. Attached is a job description listing the essential functions for the patient/employee's position. Review the essential functions and assess whether the patient/employee can perform the essential functions: Yes No

If no, which essential functions cannot be performed and why?

6. Describe any accommodations that would reasonably allow this patient/employee to be able to perform those essential functions:

7. If medical leave is one of the possible accommodations listed above, provide an estimated duration for the leave:

8. Would performing any of the essential functions listed pose a direct threat to the health and safety of the patient/employee or other people (co-workers, members of the general public, etc.)?

Yes No

If yes, describe:

a) Which essential function(s) would pose such a threat:

b) The direct safety or health threat posed:

c) Any reasonable accommodations that would eliminate the direct threat to the health and safety of the patient/employee or other people (co-workers, members of the general public, etc):

Signature of Physician or Health Care Provider

Date