Interactive Process Questionnaire
Kean University

Employee Name: ____

Title: ______________________________ Dept: ______________________________

You have requested an accommodation pursuant to the American's with Disabilities Act from Kean University. In order to review your request, please provide medical certification from your physician that addresses the following questions. The doctor may either use this form or may provide a detailed letter.

> *NOTE TO PHYSICIAN: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitles 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'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.*

1. Does this employee have a physical or mental impairment that substantially limits any major life activity? □Yes □No

   If yes, which major life activities are limited?

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   ____
   ____

2. Attached is a job description for the employee's position. Can the employee perform all job functions? □Yes □No

   If no, which job functions cannot be performed and why? What prevents the employee from performing job functions?

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3. Please describe any accommodations that Kean University could consider which would allow the employee to perform those job functions?

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4. What is the expected duration of the employee's impairment? ☐Temporary ☐Permanent

   If temporary, please indicate expected recovery date:

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5. 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 would pose such a threat, the direct threat or health threat posed, and any accommodation that might eliminate this direct safety or health threat:

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Physician's Signature

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Title

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Date

Physician's Printed Name and Address

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This form may be returned to you by the doctor or submitted directly to the following address, at your request:

Yrelys Tapanes, ADA Coordinator, Office of Human Resources, 1000 Morris Avenue, Union, NJ 07080
Fax: 908-737-3319