



FMLA ADULT CHILD DISABILITY & MEDICAL INQUIRY FORM

[Non-fillable version (fill out by hand)]

To approve your request for FMLA leave to care for your adult child, the State of New Mexico Taxation & Revenue Department is requesting medical information and documentation to determine if your adult child has a disability as defined by the Americans with Disabilities Act (ADA) and amendments.

Please have your adult child’s medical care provider complete this form. Return the completed form to your HR Analyst with the Certification of Family Member’s Serious Health Condition Form.

Employee’s Name:

First Name Last Name

Employee’s SHARE Number

**Name of Adult
Child (Patient):**

First Name Last Name

1. Can you confirm that the adult child’s serious health condition causes him or her to be incapable of self-care in at least three (3) daily living activities listed in question 2? Yes No

2. Please check all activities of which the adult child is incapable.

- | | |
|---|--|
| <input type="checkbox"/> Grooming and hygiene | <input type="checkbox"/> Washing clothes |
| <input type="checkbox"/> Bathing and dressing | <input type="checkbox"/> Shopping for normal basic living necessities |
| <input type="checkbox"/> Feeding and eating | <input type="checkbox"/> Taking public transportation |
| <input type="checkbox"/> Cooking and preparing meals | <input type="checkbox"/> Paying bills, using a bank or the post office |
| <input type="checkbox"/> Cleaning dishes | <input type="checkbox"/> Helping to maintain a residence |
| <input type="checkbox"/> Other (please specify) _____ | |

3. Does the adult child have a disability as defined by the ADA? (Such a disability would be a physical or mental impairment that substantially limits one (1) or more of the major life activities of an individual.) Yes No

Health Care Provider’s Signature Date

Health Care Provider’s Name Printed

Treating Health Care Provider’s Address Phone Number

City State Zip Code

Employee’s Signature Date