

Employee Name _____

Employee Job Title _____

**Health Care Provider Information
Americans with Disability Act
Reasonable Accommodation Request**

To be Completed by the HEALTH CARE PROVIDER

Please answer the following questions regarding the employee's condition as it relates to the essential functions and possible accommodations.

1. Does the employee have a disability that substantially limits a major life activity?
If so, describe the disability and the limitation.

2. Does the employee use any mitigating measures (medications, assistive technologies, etc.). How do the mitigating measures affect the disability?

3. Does the disability affect the employee's ability to perform any one of the essential functions of the position? yes no

If yes, please describe the impact on the person's ability to perform specific functions. Describe the effects of any mitigating measures used.

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4. Are there any accommodations that in your opinion would allow the employee to perform the essential functions of the job? If so, describe those accommodations.

5. If the employee cannot perform the essential functions of this position with or without an accommodation, what type of work, if any, can the employee perform with or without an accommodation? Please be specific.

6. Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?

Provider's name (Please print): _____

Provider signature: _____

Date: _____

Business Name and Address: _____

Type of practice/Medical Specialty: _____

Telephone: (____) _____ **Fax:** (____) _____

ADA DEFINITION OF DISABILITY

WHO IS CONSIDERED DISABLED UNDER THE ADA?

Under the ADA, a person with a disability is defined as follows:

1. "an individual with a physical or mental impairment that substantially limits one or more major life activities"
2. "an individual with a record of a substantially limiting impairment"
3. "an individual who is perceived to have such an impairment"