Americans with Disabilities Act (ADA)
Health Care Provider Form

Dear Health Care Provider (HCP):

The information you provide regarding your patient will assist in establishing the presence of a physical or mental impairment that substantially limits one or more major life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working. This information is needed in order to consider an accommodation(s) under the Americans with Disabilities Act (ADA) requested by the employee. Please review the attached job description or discuss the position with the employee in answering the following questions:

Patient's Name: _____

Patient's Job Title: _____

Patient's Work Schedule: _____

1. Is the employee able to perform the job functions of his/her position with or without a reasonable accommodation?

   Yes ____ No ____

   If yes, please proceed to question 2.

   If no, how long will employee be unable to perform these job duties?

   _____ # of weeks _____# of months _____ permanently

   *After identifying the length of time, the employee is unable to perform his/her job functions, please skip to Question 9.

2. Does the employee have a physical or mental impairment that substantially limits one or more major life activities?

   Yes ____ No ____

   If yes, what is the nature and duration of the impairment?

3. Please describe the major life activities (e.g. breathing, eating, sleeping, walking, talking, thinking manual tasks, etc.) that are substantially limited by the physical or mental impairment or accompanying treatment.

4. Please identify the employee's specific limitation(s) which are interfering with the employee's ability to perform his/her job functions or access a benefit of employment and identify which job function or benefit the employee is having trouble performing or accessing because of the limitation(s).

5. What adjustments to the work environment or position responsibilities would enable the employee to perform the functions of his/her position?

6. The employee's typical schedule is indicated above. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the functions of his/her position?

7. How would your suggestions improve the employee's job performance?

8. How long will the employee need the reasonable accommodation(s)? If you are unable to provide a date, when will he/she be medically re-evaluated?

9. Any additional comments/suggestions:

Health Care Provider (HCP) Name *(Please print):* _____

HCP license number: _____ State*:* _____

Address: _____

Telephone: _____ E-Mail Address: _____

Signature of Attending HCP: _____ Date: _____

Please return this completed form to the Patient or to:
Irving ISD Risk Management Department
Attn: ADA Advisory Committee
P.O. Box 152637, Suite 1901
Irving Texas 75015-2637
Fax: (469) 646-4320 Email: accommodations@irvingisd.net

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of employees or other family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.