ADA Accommodation Form

Employee Name: ____

Disability: ____

ADA Accommodation(s) Requested: ____

Employee Signature:_______________________________ Date: _______________________

Dear Physician,

I am requesting an employment related reasonable accommodation. To assist with this process, please complete the following questions below.

Please answer these questions to help determine disability and reasonable accommodation.

1) Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? Yes _____ No _____

   If yes, please continue to next question.

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

   ____ # of weeks ____ # of months ____ permanently

2) Does the employee have a physical or mental impairment?

   If yes, what is the impairment?

3) What limitations are interfering with job performance, and how do they affect the employee's ability to perform the job functions?

4) What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

5) Employee's typical schedule is ____.
What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform essential functions of that position?

6) How would your suggestions improve the employee's job performance?

7) How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?

Any additional comments or suggestions:

____ ______________________________

Physician Name (Please Print) Date

____

Signature of physician completing form