AMERICANS WITH DISABILITIES ACT (ADA)
MEDICAL INFORMATION REQUEST FORM

Fort Worth INDEPENDENT SCHOOL DISTRICT

Employee Name: _____ **EID#:** _____

Position: _____

Patient's Work Schedule: ☐ Full Time ☐ Part Time ☐ Other (Specify) _____

Department/Campus: _____ **Job Description Attached:** ☐ Yes ☐ No

TO BE COMPLETED BY THE EMPLOYEE'S HEALTH CARE PROVIDER

A. Employee Medical Information

In accordance with the Genetic Information Nondiscrimination Act (29 C.F.R. *§ 1635.9) do not provide any genetic information when responding to this request for medical information.*

1. 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 impairment or the nature of the impairment? _____

   _____

   What **major life activity(ies)** is/are affected?

☐ Bending	☐ Interacting w/ Others	☐ Reading	☐ Thinking
☐ Breathing	☐ Learning	☐ Seeing	☐ Walking
☐ Caring for Self	☐ Lifting	☐ Sitting	☐ Working
☐ Concentrating	☐ Performing Manual Tasks	☐ Sleeping	
☐ Eating		☐ Speaking	
☐ Hearing	☐ Reaching	☐ Standing	
☐ Other: (Describe)			

   What **major bodily function(s)** is/are affected?

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs/ Skin
☐ Cardiovascular	☐ Hemic	☐ Cell Growth	
☐ Circulatory	☐ Immune	☐ Organ Operation	
☐ Other: (Describe)			

2. What is the nature of the impairment/medical diagnosis and its duration?

   Impairment: _____

   _____

   Duration: _____

   _____

B. Limitations

1. Please identify the employee's specific limitation(s) which is interfering with the employee's job performance or with their access to a benefit of employment: _____

   _____

   _____

2. What job function(s) or benefit of employment is the employee having trouble performing or accessing because of the limitation(s)? _____

   _____

3. How does the employee's limitation(s) interfere with the employee's ability to perform the job functions or access a benefit of employment? _____

   _____

C. Accommodation Options

1. Do you have any suggestions regarding possible accommodation to allow the performance of the employee's job functions? ☐ Yes ☐ No
   If yes, what are they? _____

   _____

2. How would your suggestions allow the employee to perform the job functions?

   _____

   _____

3. For how long will the employee need the suggested accommodations? _____

D. Other Questions or Any Additional Comments:

_____

_____

E. Contact Information & Signature

Health Care Provider Name (please print) (MD, DO, or Ph.D.): _____

HCP License Number:_____ State: _____

Address: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

Please email or fax this form to Leaves and ADA Management.
Email: leaves@fwisd.org
Fax: 817-814-2185