WALLER INDEPENDENT SCHOOL DISTRICT

Health Care Provider Statement to Assist with Employee Request for Accommodations

SECTION 1 (Completed by Employee)	
Employee's Name	Position
Address	Phone

SECTION 2 Questions to help determine whether an employee has a disability. * (Completed by Health Care Provider)	
1.Does the employee have a physical or mental impairment?	___ Yes ___ No
If yes, what is the impairment? If no, please complete the information in Section 6 and return to: Angie Campbell Pulido, Chief Human Resources Officer, Waller ISD, 2214 Waller St., Waller, TX 77484.	
2.Is the impairment long-term or permanent?	___ Yes ___ No
If not permanent, how long will the impairment likely last?	
Answer the following questions based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include such things as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.	
3.Does the impairment substantially limit a major life activity?	___ Yes ___ No
If yes, what major life activity(s) is/are affected? __ Caring for Self __ Walking __ Hearing __ Lifting __ Other: (describe) __ Interacting with Others __ Standing __ Seeing __Sleeping __ Performing Manual Tasks __ Reaching __ Speaking __Concentrating __ Breathing __ Thinking __ Learning __ Reproduction ______________ __ Working __ Toileting __ Sitting	
4.Does the impairment substantially limit the operation of a major bodily function?	___ Yes ___ No
If yes, what bodily function is affected? __ Immune __ Hemic __ Circulatory __ Other: (describe) __ Normal Cell Growth __ Special Sense Organs and Skin __ Endocrine __ Digestive __ Lymphatic __ Reproductive ____________________ __ Bowel __ Neurological __ Musculoskeletal __ Bladder __ Brain __ Special Sense ____________________ __ Genitourinary __ Respiratory __ Cardiovascular	

SECTION 3 Questions to help determine whether an accommodation is needed* (Completed by Health Care Provider)	
1.Please review the job description. Is the employee able to perform the essential functions of this position without reasonable accommodation?	___ Yes ___ No
If yes, please complete the information in Section 6 and return to: Angie Campbell Pulido, Chief Human Resources Officer, Waller ISD, 2214 Waller St., Waller, TX 77484. If no, how long will the employee not be able to perform these job duties?	___ weeks ___ months ___ permanently
2.What limitation(s) is/are interfering with job performance?	
3.What job function(s) is the employee having trouble performing because of the limitation(s)?	

SECTION 4 **Questions to help determine effective accommodations*** **(Completed by Health Care Provider)**
1.Do you have any suggestions regarding possible accommodations to improve job performance? **If so, what are they?**
2.How would your suggestions improve the employee's performance?

SECTION 5 **Additional comments/helpful information from Health Care Provider*** **(Completed by Health Care Provider)**

SECTION 6 **Health Care Provider Information** **(Completed by Health Care Provider)**	
Health Care Provider's Signature	**Date**
Printed Name	
Address	
Phone	

Please return this completed form to:

Angie Campbell Pulido, Chief Human Resources Officer
Waller ISD
2214 Waller Street
Waller, TX 77484

*The Genetic Information Nondiscrimination Act of 2008 (GINA) (29CFR 165.8(b)(l)(i)(B) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, please do not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or embryo lawfully held by an individual or family member receiving reproductive services. Please do not send office visit notes as they may contain medical information not relevant to the request for accommodation.