Anchorage School District
Employee Relations Office
Phone: 907-742-4007 Fax: 907-742-4356

ADA/ADAAA Request for Accommodation and Medical Inquiry Form

Directions: Use this form to request reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA). After discussing needs with the supervisor, the individual needing accommodations must complete Section A. If the impairment or limitation is not obvious, the individual will need to have their health care provider complete Section B. If you are unable to complete this form on your own, someone else may complete the form on your behalf.

SECTION A **To Be Completed by Individual Needing Accommodation**		
Name of the individual needing this accommodation:	**Status of the individual who is needing the accommodation (Circle one):** **Student** **Employee** **Applicant** **Community Member**	**Have you discussed your ADA/ADAAA needs with your principal, manager or supervisor?** YES NO
What accommodations are being requested? Explain the individuals restrictions or limitations.	**School /Department:**	**Is accommodation needed due to a Workers Compensation injury?** YES NO If YES, claim number:
E-Mail:	**Phone (Voice/TTY):** **Fax:**	**Name of the person completing this form:**

SECTION B **To Be Completed by Health Care Provider**	
Instructions to the Health Care Provider: The employee listed above has requested accommodations under Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 (ADAAA). Please answer all fields fully and completely. Several questions seek a response to the frequency or duration of condition, treatment etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine ADA Reasonable Accommodations. Please limit your responses to the condition for which the patient has requested an ADA Accommodation. Please be sure to sign the backside of the form.	
1. Does the Employee have a physical or mental impairment? Yes ☐ No ☐ If yes, what is the impairment?	**1a. Is the impairment long-term or permanent?** Yes ☐ No ☐ If not permanent, how long will the impairment likely last?

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(Section B, Continued)

Please answer the following questions based on what limitations the employee has when his/her condition is in an active state and what limitations the employee would have if no mitigating measures were used.

2. Does the impairment substantially limit a major life activity? Yes ☐ No ☐

2a. If yes, what major life activity(s) is/are affected?

☐ Caring For Self	☐ Walking	☐ Hearing	☐ Lifting	☐ Speaking
☐ Interacting With Others	☐ Standing	☐ Seeing	☐ Sleeping	☐ Performing Manual Tasks
☐ Reaching	☐ Concentrating	☐ Breathing	☐ Thinking	☐ Learning
☐ Reproduction	☐ Working	☐ Toileting	☐ Sitting	☐ Other: (describe)

3. Does the impairment substantially limit the operation of a major bodily function? Yes ☐ No ☐

3a. If yes, what bodily function(s) is/are affected?

☐ Immune	☐ Hemic	☐ Circulatory	☐ Normal Cell Growth	☐ Special Sense Organs and Skin
☐ Normal Cell Growth	☐ Endocrine	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Neurological	☐ Special Sense	☐ Musculoskeletal	☐ Bladder
☐ Brain	☐ Genitourinary	☐ Respiratory	☐ Cardiovascular	☐ Other: (describe)

4. What specific restrictions and/or limitations is the employee experiencing when performing essential job functions?

5. How does the employee's limitation(s) interfere with his/her ability to perform their job function(s)?

Medical Professional's Signature **Printed Name** **Date**