

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 or Stephanie Fletcher - Waller ISD, 20600 Fields Store Rd., 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? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 20%;">☐ Caring for Self</div> <div style="width: 20%;">☐ Walking</div> <div style="width: 20%;">☐ Hearing</div> <div style="width: 20%;">☐ Lifting</div> <div style="width: 20%;">☐ Other: (describe)</div> <div style="width: 20%;">☐ Interacting with Others</div> <div style="width: 20%;">☐ Standing</div> <div style="width: 20%;">☐ Seeing</div> <div style="width: 20%;">☐ Sleeping</div> <div style="width: 20%;">☐ Performing Manual Tasks</div> <div style="width: 20%;">☐ Reaching</div> <div style="width: 20%;">☐ Speaking</div> <div style="width: 20%;">☐ Concentrating</div> <div style="width: 20%;">☐ Breathing</div> <div style="width: 20%;">☐ Thinking</div> <div style="width: 20%;">☐ Learning</div> <div style="width: 20%;">☐ Reproduction</div> <div style="width: 20%;">☐ Working</div> <div style="width: 20%;">☐ Toileting</div> <div style="width: 20%;">☐ Sitting</div> </div>	
4. Does the impairment substantially limit the operation of a major bodily function?	☐ Yes ☐ No
If yes, what bodily function is affected? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 20%;">☐ Immune</div> <div style="width: 20%;">☐ Hemic</div> <div style="width: 20%;">☐ Circulatory</div> <div style="width: 20%;">☐ Other: (describe)</div> <div style="width: 20%;">☐ Normal Cell Growth</div> <div style="width: 20%;">☐ Special Sense Organs and Skin</div> <div style="width: 20%;">☐ Endocrine</div> <div style="width: 20%;">☐ Digestive</div> <div style="width: 20%;">☐ Lymphatic</div> <div style="width: 20%;">☐ Reproductive</div> <div style="width: 20%;">☐ Bowel</div> <div style="width: 20%;">☐ Neurological</div> <div style="width: 20%;">☐ Musculoskeletal</div> <div style="width: 20%;">☐ Bladder</div> <div style="width: 20%;">☐ Brain</div> <div style="width: 20%;">☐ Special Sense</div> <div style="width: 20%;">☐ Genitourinary</div> <div style="width: 20%;">☐ Respiratory</div> <div style="width: 20%;">☐ Cardiovascular</div> </div>	
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 or Stephanie Fletcher - Waller ISD, 20600 Fields Store Rd., 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, ADA Coordinator
Stephanie Fletcher, ADA Administrator
Waller ISD
20600 Fields Store Road
Waller, TX 77484

*The Genetic Information Nondiscrimination Act of 2008 (GINA) (29CFR 165.8(b)(1)(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.