STATE OF ALASKA
Americans with Disabilities Act Accommodation Request
Employee Documentation

Part A: Employee Information

Employee Name		Contact Telephone Number
Job Title	Position Control No.	Department
Division	Section (Work Unit)	Location (City)
Supervisor's Name		Supervisor's Work Telephone

Part B: These questions will help determine whether you have a disability as defined by the ADA.

1. Do you have a physical or mental impairment that affects your ability to perform your job?

☐ Yes ☐ No

A. If yes, what is the impairment?

B. If yes, is the impairment long-term or permanent? ☐ Yes ☐ No

1. If not permanent, how long will the impairment likely last?

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

A. If yes, what major life activity (activities) is (are) affected? (check one or more)

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

B. If yes, how does the impairment substantially limit the major life activity?

3. Does the impairment substantially limit the operation of a major bodily function?

☐ Yes ☐ No

A. If yes, what major bodily function is affected? (check one or more)

☐ Normal Cell Growth	☐ Bladder	☐ Endocrine
☐ Immune	☐ Neurological	☐ Musculoskeletal
☐ Digestive	☐ Respiratory	☐ Cardiovascular
☐ Bowel	☐ Circulatory	☐ Brain
☐ Other (please describe):		

Part C: Questions regarding the reason for accommodation request.

1. What, if any, specific job functions are you having difficulty performing or what benefit(s) of employment are you having difficulty accessing?

2. What, if any, limitation is interfering with your ability to perform your job or access an employment benefit?

Part D: Questions to clarify accommodation request.

1. Please describe the specific accommodation(s) that you are requesting.

2. Please explain how the accommodation(s) you are requesting will enable you to perform the essential functions of your job or access an employment benefit.

3. If you are unsure what accommodation(s) is (are) needed, do you have any suggestions about what options we can explore?

4. Please provide any additional information that you believe might be useful as your accommodation request is being reviewed.

Part E: Signature and return information.

Employee's Signature

Date

Please return this confidential form to:

STATE OF ALASKA
Americans with Disabilities Act Accommodation Request
Employee Authorization for the Release of Medical Information

I authorize _____(health care provider name) to release to my employer, the State of Alaska, medical information relevant to my request for accommodation under the Americans with Disabilities Act (ADA). The information will be used to determine my eligibility for workplace accommodations under the ADA and, if eligible, what reasonable accommodation(s) can be made.

I also authorize my treating physician or health care provider to speak with my employer in regard to any questions that specifically relate to my medical condition(s), the performance of my job, and any workplace accommodations.

This authorization will remain valid for 180 days after the date of my signature or earlier if revoked in writing to the State of Alaska. A facsimile, scan, or photocopy is as valid as the original.

I acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information is not released, my accommodation(s) may be denied.

_____ _____

Employee Name (please print) Work Telephone

_____ _____

Employee Signature Date

Notice to Medical Provider: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, the State of Alaska, as an employer, asks that you 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 an 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 an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Attachment(s):

- ☐ Health Care Provider Documentation (EEOP Form 502)
- ☐ Letter from State of Alaska employing agency requesting provider information
- ☐ Position Description for _____

STATE OF ALASKA
Americans with Disabilities Act Accommodation Request
Health Care Provider Documentation

Employee Name	Position Control Number

Please return completed form to:

Note to Health Care Provider: Attached to this form is a description of duties and responsibilities of the position held by the employee named above. Please answer the following questions regarding the employee's medical condition as it relates to the duties of the position and possible workplace accommodations under the Americans with Disabilities Act (ADA). The employee's signed authorization for the release of medical information is also attached.

Part A: These questions help to determine whether the employee has a disability as defined by the ADA.

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No

A. If yes, what is the impairment?

B. If yes, is the impairment long-term or permanent? ☐ Yes ☐ No

1. If not permanent, how long will the impairment likely last?

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

A. If yes, what major life activity (activities) is (are) affected? (check one or more)

☐ Breathing	☐ Walking	☐ Learning
☐ Hearing	☐ Reaching	☐ Performing Manual Tasks
☐ Seeing	☐ Lifting	☐ Working
☐ Speaking	☐ Sleeping	☐ Reproduction
☐ Sitting	☐ Concentrating	☐ Caring for Self
☐ Standing	☐ Thinking	☐ Toileting

☐ Other (please describe):

B. If yes, how does the impairment substantially limit the major life activity?

3. Does the impairment substantially limit the operation of a major bodily function?

☐ Yes ☐ No

A. If yes, what major bodily function(s) is (are) affected? (check one or more)

☐ Normal Cell Growth	☐ Bladder	☐ Endocrine
☐ Immune	☐ Neurological	☐ Musculoskeletal
☐ Digestive	☐ Respiratory	☐ Cardiovascular
☐ Bowel	☐ Circulatory	☐ Brain
☐ Other (please describe):		

Part B: If the employee has an ADA qualifying disability noted in Part A, please answer the following questions. These questions help to determine whether a workplace accommodation is needed because of the disability.

1. What limitation(s) is (are) interfering with job performance or accessing a benefit of employment?

2. What job function(s) or benefit(s) 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 his or her ability to perform the job function(s) or access a benefit of employment?

Part C: If the employee has an ADA qualifying disability noted in Part A, please answer the following questions. These questions help to determine effective, reasonable accommodation options.

1. Based on your professional judgment, do you have any suggestions regarding possible workplace accommodations that would allow the employee to perform the functions of the job? If so, what are they?

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

3. Comments:

Part D: Contact Information and Signature

Health Care Provider Name (printed or typed):	Title	Telephone

Street Address	City, State

Health Care Provider's Signature

Date

☐ Health Care Provider: Please check if you reviewed the attached Position Description.

Statement Regarding GINA: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we ask that you 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 an 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 an embryo lawfully held by an individual or family member receiving assistive reproductive services.