ADA Request Medical Form

Employee Name: _____ Title/Division: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER/PRACTITIONER

The teammate listed above indicated they may have a disability that may be covered under the Americans with Disabilities Act. To make an appropriate determination, we are seeking your cooperation by asking that this form be completed in its entirety.

Health Care Provider name (please print):_____

Type of Provider/Practitioner (please print):_____

Area of Practice: _____

Name of Practice if applicable: _____

Practice Address: _____

Phone Number: _____Fax: _____

1. Please review the attached job description and/or list of essential job duties. Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?

   _____
   _____
   _____
   _____
   _____
   _____

2. Identify and describe any physical or mental impairment that substantially limits one or more of the major life activities of this employee.

   _____
   _____
   _____
   _____
   _____
   _____

3. Describe the extent, duration, and impact of the impairment.

_____
_____
_____
_____
_____
_____

4. Please review the information provided by the employee, on the accompanying Reasonable Accommodation Request form, and answer the following questions:

   Do you agree with the employee's statements?

_____
_____
_____
_____
_____
_____

   If not, with what do you disagree?

_____
_____
_____
_____
_____
_____

   Do you have any recommendations for accommodations?

_____
_____
_____
_____
_____
_____

_____ _____

Health Care Provider/Practitioner Signature Date of Completion

Please send this completed form to Human Resources Shared Services to one of the following:

Attention: Human Resources
Phone: 402.840.0017
Fax: 402.742.8361
Email: das.humanresources@nebraska.gov