ADA Form 2

NEWPORT NEWS PUBLIC SCHOOLS

AMERICANS WITH DISABILITIES ACT
REASONABLE ACCOMODATION REQUEST

DOCUMENTATION IN SUPPORT OF REQUEST: HEALTHCARE PROVIDER INFORMATION

Attached to this form is the current job description of the essential functions of the position occupied by _____ (employee name). Please answer the following questions regarding the employee's condition as it relates to the essential functions and possible accommodations. The employee's signed release is also attached.

1. Does the employee have a disability that substantially limits a major life activity? If so, describe the disability and the limitation.

2. Does the employee use any mitigating measures (medications, assistive technologies, etc.)? How do the mitigating measures affect the disability?

3. Does the disability affect the employee's ability to perform any one of the essential functions of the position? □YES □ NO
If yes, please describe the impact on the person's ability to perform specific functions. Describe the effects of any mitigating measures used.

4. In your opinion, are there any accommodations that would allow the employee to perform the essential functions of the job? If so, describe these accommodations.

5. Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation to exist?

Provider Name (print):_____ Signature:_____

Professional License or Specialty:_____ Date:_____

ADA DEFINITION OF DISABILITY –
WHO IS CONSIDERED DIASBLED UNDER THE ADA?

Under the ADA, a person with a disability is defined as follows:

1. "An individual with a physical or mental impairment that substantially limits one or more major life activities of such individual";
2. "An individual with a record of such impairment"; or
3. "An individual regarded as having such an impairment [as defined in the ADA]."

Please submit the completed form to:

(Fax) 757-643-7405
(Office) 12507 Warwick Boulevard, Newport News, VA 23606