



City & Borough of Juneau
Americans with Disabilities Act (ADA) Health Care Provider Information

Employee Name: _____

Position title and number _____

Please return the completed form to employee or to the:
Human Resources and Risk Management Department
c/o Human Resources
155 South Seward Street
Juneau, AK 99801
907-586-5250 FAX 907-586-4509

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 determine whether the employee has a disability as defined by the ADA.

1. Does the employee have a physical or mental impairment?
 - If yes, what is the impairment?
 - If yes, is the impairment long term-or permanent?
 - If not permanent, how long will the impairment likely last?

2. Does the impairment substantially limit a major life activity? Yes ____ No ____
If yes, what major life activity (activities) is (are) affected? (check one or more)
 - ☐ Breathing
 - ☐ Hearing
 - ☐ Seeing
 - ☐ Speaking



- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Reaching
- ☐ Lifting
- ☐ Sleeping
- ☐ Concentrating
- ☐ Thinking
- ☐ Learning
- ☐ Performing Manual Tasks
- ☐ Working
- ☐ Reproduction
- ☐ Caring for Self
- ☐ Toileting
- ☐ Other, please describe.

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 ____

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 a 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.?



Health Care Provide'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.

