



Pflugerville ISD
Documentation in Support of Americans with Disabilities Act Request:
Health Care Provider Information

Attached to this form is the current job description of the essential functions of the position occupied by _____ (PfISD employee), including the physical and mental demands of the job.

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.

To be completed by the attending medical physician:

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 employee's ability to perform specific functions. Describe the effects of any mitigating measures used.

4. Are there any accommodations that in your opinion would allow the employee to perform the essential functions of the job? If so, describe those accommodations.

5. If the employee cannot perform the essential functions of this position with or without an accommodation, what type of work, if any, can the employee perform with or without an accommodation? Please be specific.

6. Is the need for accommodation likely to be temporary or permanent?

Temporary Permanent

7. If temporary, will the impairment last longer than 6 months? yes no

Provider name (Please print)

Professional license or specialty

Office phone number

Office fax number

Signature

Date

Pflugerville ISD
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Employee Release

ADA DEFINITION OF DISABILITY

WHO IS CONSIDERED DISABLED 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"
2. "an individual with a record of a substantially limiting impairment"
3. "an individual who is perceived to have such an impairment"

I hereby authorize _____ to provide the medical information requested by my employer. The information will be used to evaluate my request for reasonable accommodation under the Americans with Disabilities Act.

I further authorize Pflugerville ISD to contact my medical provider if further clarification is needed.

Employee Name (Please print)

E-number

Signature

Date