ARKANSAS DEPARTMENT OF EDUCATION

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

Employee's Name:_____ DOB:_____

Functional Job Title: _____ Division: _____

Please have this form completed by the health care provider most knowledgeable about your condition and treatment, along with your accurate, up-to-date functional job description as provided by your supervisor.

Important ADE Notice to Health Care 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 of the individual, except as specifically allowed by this law. To comply with this law, we are asking 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.

1. Does the employee have a disability or impairment that substantially limits a major life activity? If so, describe the disability and the limitation(s), including limitations caused by side effects of medication, treatment, or other mitigating measures.

2. Please review the enclosed functional job description. Does the employee's disability affect his or her ability to perform any function(s) of the position? ☐ Yes ☐ No
If yes, please describe the impact on the person's ability to perform specific work-related functions, including frequency and severity of that impact.

3. 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.

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

Healthcare Provider Information

Provider Name		Professional License or Specialty	
Provider Signature		Signature Date	
Employee Name		AASIS Personnel Number	
Employee Signature		Signature Date	

Please return this completed form to the ADE Human Resources ADA Coordinator no later than _____:

Arkanas Department of Education
Human Resources
Four Capitol Mall, Room 106A
Little Rock, AR 72201
Phone: (501) 682-2744 Fax: (501) 682-4487