



3. Describe the **detrimental effects** of all of the mitigating measures, e.g., medication, therapy, assistive devices, as they affect my participation in, or performance of the above identified major life activities, compared most people in the general population.
  
4. **Prognosis:** Are my impairments and/or limitations **permanent, or will there be changes** over time? Please **describe any anticipated changes** and include the bases for your opinions.
  
5. If my condition is episodic or in remission, please identify and detail the **nature, frequency, severity and duration** of anticipated future episodes. Please detail accommodations that may help me to perform the essential functions of my position.

**Frequency:** \_\_\_\_\_ Times per \_\_\_\_\_ Week \_\_\_\_\_ Month

**Duration:** \_\_\_\_\_ Hours or \_\_\_\_\_ days per episode

6. According to my employer, I am required to perform essential functions relative to my current position as \_\_\_\_\_. Please see the attached job description for these functions.

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3. The U.S. Equal Employment Opportunity Commission has indicated that an **employer never has to remove an essential function of the job** as an accommodation. Additionally, **an employee with a disability must meet the same performance and production standards, whether quantitative or qualitative**, as a non-disabled employee in the same job. Lowering or changing a production standard because an employee cannot meet it due to a disability is not considered a reasonable accommodation. Similarly, **an employee who is chronically, frequently, and unpredictably absent may not be able to perform one or more essential functions of the job**, or the employer may be able to demonstrate that any accommodation would impose an undue hardship, thus rendering the employee unqualified. **Employers generally do not have to accommodate repeated instances of tardiness or absenteeism** that occur with some frequency, over an extended period of time and often without advance notice. The Americans with Disabilities Act: Applying Performance and Conduct Standards To Employees With Disabilities.

7. Please provide your opinion concerning my ability to perform the essential functions of my position, given your diagnosis and prognosis of my health condition(s). Please include the facts and pertinent health information that support your opinion.
  
8. In your opinion, what **accommodations**, if any, **will enable me to perform the essential functions of my employment position?** Please indicate how your recommended accommodations will assist me in performing those essential functions.
  
9. Please indicate the potential effectiveness and reasoning for each of the accommodations proposed.

Please feel free to provide any additional comments you believe might be helpful in determining what accommodation(s) might be appropriate. Thank you for your time and assistance.

**Once completed, please fax this form to the ADA coordinator at 801-997-4722.**

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VERIFICATION

(To be signed by the professional who has completed this form)

I, the undersigned, affirm that I have provided the information above and that said information is true and correct to the best of my knowledge and belief.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_