LETTER TO HEALTH CARE PROVIDER(S)

CONFIDENTIAL

Date: _____

RE: My ADA request

Dear Dr _____:

I have submitted a request for a reasonable accommodation to my employer under the Americans with Disabilities Act. The law allows my employer to conduct an individual assessment of my condition[1] before granting or denying a request for accommodation. Please review your files and respond to the listed questions to assist my employer in undertaking that assessment. **In compliance with The Genetic Information Nondiscrimination Act of 2008 (GINA), please do not include genetic or family history information in response to this request for medical information.**

1. What is your **diagnosis** of my physical and/or mental health condition(s), per the International Classification of Diseases (ICD 10) or Diagnostic and Statistical Manual (DSM IV)?

2. **Comparing me to most people in the general population**, please identify each **major life activity or major bodily function** that is substantially limited by my health condition(s). Please indicate how and to what extent each major life activity is limited. **Specify the functional limitations. (Quantify where possible. ie how far, how long, how much)**

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1. The Statutory Definition of disability is a person with a physical or mental impairment that substantially limits one or more of the major life activities of such individual. 42 U.S.C. § 12102(2); see also 29 C.F.R. § 1630.2(g).

2. According to the Americans with Disabilities Amendments Act, Major life activities may include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and major bodily functions. Major bodily functions include but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. Public Law 110–325—Sept. 25, 2008. This is not an exhaustive list of all major life activities. Rather it is representative of the types of activities that are major life activities. Similar activities in terms of their impact on an individual's functioning, as compared to the average person, may also be major life activities.

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.

Please send the requested information to the ADA coordinator via fax at 801-997-4722 or by mail to: **Salt Lake Community College**
Attn: Jill Tew - AAB/201Z
PO Box 30808
Salt Lake City, UT 84130-0808

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.

Date:_____ Signature :_____

Print Name: _____