LDH REQUEST FOR ACCOMMODATION FORM

CONFIDENTIALITY STATEMENT:
A request for accommodation, including medical and other relevant information, is privileged and may only be released as appropriate to individuals with a business need to know.

SECTION 1: REQUESTOR INFORMATION

Requestor's Name: _____

Requestor is *(check only one)*: ☐ Employee ☐ Job Applicant ☐ Visitor / Public

Requestor's Email Address: _____

Requestor's Phone #: _____

If Requestor is an employee, also provide: Personnel No. _____

Job Title: _____

Division/Unit: _____ Supervisor's Name: _____

SECTION 2: REQUESTED ACCOMMODATION *(Attach a separate sheet if additional space is needed)*

A. Please describe the nature of your disability and the functional limitations resulting therefrom.

_____

_____

_____

B. Check the type of accommodation requested. Use the blank space provided to the right to further explain reason for the requested accommodation.

	Accommodation Type:	Reason for Accommodation Request:
1.	☐ Application/Testing Process Explain the specific application/testing requirement for which accommodation is requested: (→)	
2.	☐ Participating in a Job Interview Identify the Date/Time/Location of the job interview for which an accommodation is requested: (→)	
3.	☐ Performance of Essential Functions of Your Job Explain the job duties for which accommodation is requested: (→)	
4.	☐ Benefits/Privileges of Employment Explain the benefits or privileges of employment for which accommodation is requested: (→)	
5.	☐ Pregnancy, Childbirth or Related Condition Explain how pregnancy, childbirth or a related condition affects your ability to perform your job: (→)	
6.	☐ Effective Communication Identify the Date/Time/Location for which an auxiliary aid is requested: (→)	
7.	☐ Access to Programs, Services or Facilities Identify the specific program, service or facility for which access is needed: (→)	

C. Describe the accommodation(s) requested. *(Identify specific auxiliary aid requested, if applicable)*

_____

_____

Requestor's Signature: _____ Date: _____

MEDICAL INQUIRY
RESPONSIVE TO LDH EMPLOYEE ACCOMMODATION REQUEST

FOR COMPLETION BY EMPLOYEE

CONFIDENTIALITY STATEMENT:
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Employee's Name: _____

Authorization for Release of Medical Information

I authorize my Healthcare Provider to release medical information that is specifically related to and necessary for my employer to determine whether I have a disability for which an accommodation(s) may be needed. I authorize my Healthcare Provider to speak directly to my Agency ADA Coordinator in regards to my medical condition and its effects upon my ability to perform the essential functions of my job. I understand that I may refuse to sign this Authorization. However, I understand that my failure to permit these disclosures may impact my employer's ability to fully address my request for accommodation.

Employee's Signature: _____ Date: _____

FOR COMPLETION BY HEALTHCARE PROVIDER

SECTION 1: Questions to determine whether employee has a disability

For reasonable accommodation under the Americans with Disabilities Act (ADA), an employee has a disability if they have an impairment that substantially limits one or more major life activities or they have a record of such an impairment. The following information may help to determine whether an employee has a disability:

Does the employee have a physical or mental impairment?

☐ Yes *(proceed to section A. below)* ☐ No *(discontinue completion of form)*

A. What is the specific medical diagnosis causing or contributing to the impairment?

_____
_____
_____
_____

B. Does the impairment substantially limit a major life activity?

☐ Yes ☐ No

C. What major life activity(s) and/or major bodily function(s) is limited?

Major Life Activities:

☐ Bending	☐ Eating	☐ Lifting	☐ Seeing	☐ Standing
☐ Breathing	☐ Hearing	☐ Performing Manual Tasks	☐ Sitting	☐ Thinking
☐ Caring for Self	☐ Interacting with Others	☐ Reaching	☐ Sleeping	☐ Walking
☐ Concentrating	☐ Learning	☐ Reading	☐ Speaking	☐ Working
☐ Other: _____				

Major Bodily Functions:

☐ Bladder	☐ Circulatory	☐ Hemic	☐ Neurological	☐ Respiratory
☐ Bowel	☐ Digestive	☐ Immune	☐ Normal Cell Growth	☐ Special Sense

☐ Brain ☐ Endocrine ☐ Lymphatic ☐ Operation of an Organ ☐ Organs & Skin
☐ Cardiovascular ☐ Genitourinary ☐ Musculoskeletal ☐ Reproductive
☐ Other: _____

D. What is the extent to which the impairment limits the ability to perform the major life activity(s) and/or the major bodily function(s)? _____

E. What is the duration of the impairment? _____

SECTION 2: Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following information may help determine whether the requested accommodation is needed because of the disability:

A. What job duties is the employee unable to perform or having difficulty performing? _____

B. How does the employee's functional limitation(s) interfere with their ability to perform required job duties? _____

Health Care Provider's Signature: _____ **Date:** _____

Health Care Provider's Name (Printed): _____
Practice Specialty: _____
Clinic Name: _____
Address: _____
Telephone #: _____ Fax #: _____

HEALTH CARE PROVIDER: RETURN COMPLETED FORM TO EMPLOYEE

EMPLOYEE: EMAIL COMPLETED FORM DIRECTLY TO LDH-ADAaccommodationrequest@la.gov