



COUNTY OF ALBANY HUMAN RESOURCES

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ADA MEDICAL DOCUMENTATION REQUEST

Name of Employee _____ Phone Number _____

Department _____ Name of Supervisor _____

Dear Health Care Provider:

Albany County Government and the employee named above are requesting that you examine him/her to provide information regarding two general issues: (a) whether the employee has a physical or mental impairment that substantially limits one or more major life activities, including any functional limitations associated with such impairment(s), and (b) whether the employee's medical condition precludes work performance and suggested accommodations that would enable the employee to perform all the essential functions of his/her position. Please respond fully to the questions that follow and attach additional information if necessary.

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.

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1. Does the employee have an impairment? Impairment meaning any physiological disorder or condition affecting one or more of the body's systems, including mental conditions. For purposes of this question, please evaluate the employee in his/her untreated state; that is, without the benefits of medication or other ameliorative measures. ___Yes ___No
 2. If yes, does the impairment affect a major life activity? Major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. ___Yes ___No
 3. If yes, please identify the major life activity or activities.

4. If yes, does the impairment affect a major bodily function such as the functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, reproductive functions? ___Yes ___No

5. If yes, please identify the major bodily function.

6. If yes, is the employee's ability to perform the major life activity substantially limited by the impairment compared to how an average person in the general population performs the activity? Substantial limitation means that the employee is restricted as to the condition, manner, or duration under which he/she performs the activity. ___Yes ___No

7. Is this condition permanent or temporary? Please explain.

8. If temporary, when would the impairment reasonably be expected to no longer limit a major life activity?

To help you better understand the employee's job for purposes of assessing capabilities and limitations, please refer to the written job description if provided. Please contact Human Resources with any questions or concerns about the employee's job.

9. Is there a medical reason why the employee cannot perform any functions of the job as described to you?
___Yes ___No

10. If yes, what function(s) cannot be performed?

11. What is the medical reason for the employee's inability to perform the identified job functions?

12. Can you identify a reasonable accommodation that may enable the employee to perform the functions of the job? ___Yes ___No

Examples of potential accommodation include restructuring a job, modification of work tools or equipment, a modified work schedule, or provision of qualified readers or interpreters.

13. If yes, please provide specific examples of accommodations that may enable the employee to perform the effected job function, or that may overcome an identified barrier in the workplace associated with the impairment.

14. Is there a medical reason to believe that the employee is likely to experience injury, harm, or aggravation of an impairment by performing or attempting to perform his/her job? ___Yes ___No

15. If yes, what is the degree of injury, harm, or aggravation that should be expected, and what is the likelihood that it will occur? Please also address the duration of the risk and the medical basis for your conclusions.

Thank you for your professional attention to this matter. Please assist us further by signing below to indicate that you have personally evaluated the employee and reviewed any attached medical information and job description if provided to you.

Health Care Provider

Date

Print Name and Title