ADA Evaluation Tool

This form is to be completed by the Physician

Please complete the evaluation tool below to assist us in determining our employee's eligibility for accommodation under the Americans with Disabilities Act of 1990. Medical records are not necessary.

Employee Name

What is the impairment?

Does the impairment affect a major life activity?

☐ Yes
☐ No

What are the functional limitations of the impairment?

☐ Caring for self	☐ Interacting with others	☐ Sitting
☐ Performing manual tasks	☐ Breathing	☐ Learning
☐ Walking	☐ Writing	☐ Typing
☐ Speaking	☐ Hearing	☐ Driving
☐ Toileting	☐ Sleeping	☐ Standing
☐ Reaching	☐ Concentrating	☐ Other _____
☐ Thinking	☐ Lifting	_____

If the employee uses mitigating measures, does the impairment still affect a major life activity?

☐ Yes
☐ No

If so, which of the following activities are affected even when mitigating measures are employed?

☐ Caring for self	☐ Interacting with others	☐ Sitting
☐ Performing manual tasks	☐ Breathing	☐ Learning
☐ Walking	☐ Writing	☐ Typing
☐ Speaking	☐ Hearing	☐ Driving
☐ Toileting	☐ Sleeping	☐ Standing
☐ Reaching	☐ Concentrating	☐ Other _____
☐ Thinking	☐ Lifting	_____

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Is the impairment permanent?
☐ Yes
☐ No
Comments:

What are your recommendations, if any, for accommodating the disability?
1.

2.

3.

Comments:

Any additional information to consider?

Doctor's Printed Name:_____ Date:_____
Business Address:_____
Business Phone Number: _____Business Fax:_____
Doctor's Signature:_____

Employee: Submit this medical certification together with your request for a reasonable accommodation to Leave.Management@state.nm.us