



Canyons School District ADA Information Sheet

Date: _____ Name of Employee: _____

Name and Title of Person Completing This Form: _____

1. Does this individual currently have a physical or mental impairment? _____
 If yes, what is the specific diagnosis? _____

2. Does this impairment substantially limit one or more major life activities? (Major life activities are those which an average person can perform with little or no difficulty, such as walking, talking, hearing, seeing, thinking, concentrating, working with others, etc.)

3. Describe the nature, severity, and anticipated duration of the impairment, including the anticipated healing period (be specific).

Temporary (Please Explain) _____

Temporary, but will take longer than normal to heal (Please Explain): _____

Temporary with residual effects (Please Explain): _____

Permanent/Chronic (Please Explain): _____

4. Please list any specific functional limitations resulting from the impairment.

5. Please review the functional job description included with this form. How do(es) the functional limitations listed impact the individual's ability to perform the essential functions identified on his or her functional job description? _____

6. If you answered: "yes" to question #1 above, are there any reasonable accommodations you would suggest that may enable this employee to perform the essential functions identified on the functional job description? If so, what suggestions do you have? _____

Physician's Signature: _____ Date: _____