CITY/BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Request for Documentation for Determining ADAAA Eligibility from a Medical Professional and Authorization for Release of Medical Information

Date: _____

Medical Provider Address: _____
_____
_____

Re: _____ _____
(Name of Patient) (Birth date or SSN)

_____
Patient Address City State Zip

Your patient, _____ (Employee Name), is an employee of the City and Borough of Juneau (CBJ) and has requested a reasonable accommodation for his/her work duties. In order to fulfill our responsibility as an employer under the Americans with Disability Act as Amended, specific information is being requested at this time. A Release of Information is below.

Please do not send copies of medical records. CBJ is not authorized to retain medical records nor qualified to interpret them. Enclosed please find a self-addressed stamped envelope. Please complete the attached questionnaire and return the questionnaire to the CBJ Supervisor indicated on the envelope. Thank you in advance for your prompt reply to this inquiry.

Employee Name: _____ Job Title: _____

Date of Request: _____ Department: _____

I hereby authorize _____ (Doctor's Name), to provide the medical information requested by my employer, City and Borough of Juneau (CBJ). The information will be used to determine my ability to perform the essential functions of my position and to evaluate possible accommodations under the Americans with Disability Act (ADA).

_____ _____
Employee Name (Print) Work Telephone

_____ _____
Employee Signature Date

Attachments:

- Description of Essential Functions
- Employee Request for Reasonable Accommodation
- Health Care Provider Information Form