STATE OF UTAH
DEPARTMENT OF (Name)
OFFICE OF (Name)

ADA COORDINATOR INTAKE FORM

The purpose of this form is to assist the employer in determining whether, or to what extent, a workplace accommodation is appropriate to enable an employee to perform the essential functions of his/her job.

This form should be completed when an employee has requested a workplace accommodation. This form, and all other ADA-related information, should be maintained in a confidential file separate from the employee's personnel file.

Date:____________________

Employee Name: ________________________________

Job Title: _______________________________________

Initiation of ADA process (date, time, circumstances, persons involved):
____
____
____

Accommodation(s) Requested: ____
____
____
____
____

Mental/Physical Impairment(s) (include date of onset): __________________________
____
____
____
____

Major Life Activities Impacted: ____
____
____
____
____
____
____

Functional limitations (nature, frequency, severity, duration) of each impairment on Major life activities (Quantify where possible. ie: how far, how long, how much. see diagnosis impairment questions if needed): ______________________________________

____
____
____
____
____

Attach Evaluation Grid if appropriate: Y___ N___

Essential Functions of the Job (attach job description and performance appraisals):

____
____
____
____
____
____
____
____
____

Marginal Functions of the Job: ____

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____
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Potential Solutions:

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____
____
____

Ergonomic Evaluation Requested: Y___ N___ Date: __________ Who: _____________

Interim Modifications if any:

____
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____
____
____
____

Name: ____ Title: ______________________