COLORADO DEPARTMENT OF TRANSPORTATION

EMPLOYEE STATEMENT OF IMPAIRMENT EFFECTS

Instructions: The purpose of this form is to give you an opportunity to provide information that is necessary to establish your eligibility for consideration of an Americans With Disabilities Act (ADA) reasonable accommodation in your job. This form will assist you to describe the overall effect of the disabling condition that is being evaluated.

Please submit this form to the ADA Representative.

Section 1 Completed by employee

Name: (Last)	**(First)**	**(Middle)**
Employee Job Classification:	**Your Work Telephone #:**	
Region:	**Supervisor's Name:**	**Home Telephone #:**
Home Address:	**City:**	**Zip:**

The purpose of this form is for both the employee and the employer to begin an interactive process for consideration of the employee under the Americans With Disabilities Act (ADA). This form will assist you to describe the overall effects of the physical or mental impairment (condition) that is being evaluated. Please submit this form to the ADA Representative in your Region; or, in the case of a CDOT Headquarters employee, to the CDOT ADA Coordinator.

An individual meets the definition of a "person with a disability" under the ADA if he/she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include the operation of a major bodily function including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Please Answer the Following:

1**.** State what your impairment is. For example, injury to right leg, partial hearing loss, severe headaches, not able to remember instructions, etc.

2. Explain how your impairment affects your ability to perform your work duties. Provide examples. Except in rare circumstances, your statements will require verification from a physician.

JOB DUTIES	**LIMITATIONS ON JOB ACTIVITIES/DUTIES**
A.	

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JOB DUTIES	LIMITATIONS ON JOB ACTIVITIES/DUTIES
B.	
C.	
D.	

3. Explain how your impairment affect your ability to perform activities that the average person must perform in his/her normal daily life away from work. List the activities and the effect of your impairment on each. This information may require verification from a physician.

NON-WORK	LIMITATIONS ON NON-WORK ACTIVITIES
A.	
B.	
C.	
D.	

CERTIFICATION:

I certify that all information provided on this form is true, complete and correct to the best of my knowledge and is made in good faith. I understand that if requested, I can and will supply documentation that will confirm the accuracy of the information provided on this form.

_____ _____

Signature Date