

Alaska Department of Corrections Prisoner ADA Request: Health Care Provider Information

Attached to this form is the current description of the programs / services offered at (institution), including the physical and mental demands of the program / service. Please answer the following questions regarding the prisoner's condition as it relates to possible accommodations. The prisoner's signed release is also attached.
1. Does the prisoner have a disability that substantially limits a major life activity? If so, describe the disability and the limitation.
2. Does the prisoner use any mitigating measures (medications, assistive technologies, etc.)? How do the mitigating measures affect the disability?
3. Does this disability affect the prisoner's activities of daily living? If so, please describe the impact.

4. Does the disability affect the prisoner's ability to painstitution? If so, please describe the impact.	rticipate in programs / services of the
5. Are there any accommodations that in your opinion, thi those accommodations.	is prisoner needs? If so, please describe
6. Is the need for accommodation likely to be temporary o do you estimate the need for accommodation will exist? WI date?	
Provider Printed Name	Professional License Or Specialty
Provider Signature	Date
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