Alaska Department of Corrections
ADA Health Care Provider Information

Documentation in Support of Request: Health Care Provider Information

Attached to this form is the current description of the programs/services offered at _______________________(correctional 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 the disability affect the prisoner’s ability to participate in programs/services of the institution? If so, please describe the impact on the ability to participate. Describe the effects of any mitigating measures used.
4. Are there any accommodations that in your opinion would allow the prisoner to participate in programs/services? If so, describe those accommodations.

5. Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?

_________________________________   __________________________
Provider name (Please print)     Professional license or specialty

_________________________________   __________________________
Signature       Date