VOLUNTARY SELF-IDENTIFICATION OF DISABILITY FORM

Office of the State Americans with Disabilities Act Coordinator (OSADAC) – *Rev. 4/2025*

Employee Name: _____ Personnel #: _____

Agency Name: _____

Why are you being asked to complete this form?

The agency is required by La. R.S. 46:2597 to establish annual strategies and goals related to employment of individuals with disabilities. In order to effectively measure and report our progress to this end, La. R.S. 46:2597 requires us to ask employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five (5) years.

Identifying yourself as an individual with a disability is **voluntary**, and we hope that you will choose to do so (if applicable). Your answer will be maintained confidentially. Completing the form will not negatively impact you in any way. For more information about this form or the Americans with Disabilities Act, visit the Office of the State Americans with Disabilities Act (ADA) Coordinator's website at https://www.doa.la.gov/doa/office-of-state-ada-coordinator/.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment that substantially limits a major life activity, or if you have a history or record of such an impairment. Disabilities include, but are not limited, to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's disease or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition, for example, migraine headaches, Parkinson's disease, or Multiple Sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, Post Traumatic Stress Disorder (PTSD) or major depression

Please check ONE of the following boxes below:

☐ **YES**, I have a disability (or previously had one)

☐ **NO**, I do not have a disability

☐ I do not wish to answer

Employee Signature: _____ Date: _____

In accordance with La. R.S. 46:2597, this form shall be confidential and filed in a folder separate from the employee's personnel file.