EMPLOYEE REQUEST FOR REASONABLE ACCOMMODATION

Name of Employee:	
Current Position:	
Start Date of Accommodation Requested:	

* * * * * * * * * * * * * *

ACCOMMODATION REQUEST PROCESS

- Employee completes the accommodation request form and returns to Administrative Supervisor.
- The Administrative Supervisor will review the request and job duties. The Administrative Supervisor will discuss the accommodation requested with the District Payroll Manager. (Specifically - they will discuss the accommodations requested, not the underlying medical condition)
- Administrative Supervisor will have an interactive conversation with employee to discuss what accommodations may be made. The employee will have an opportunity to present ideas for accommodation.
- Administrative Supervisor will provide employee with formal letter outlining any potential accommodations that will be offered.

* * * * * * * * * * * * * *

The purpose of this form is to provide you, the employee, with a formal opportunity to request an accommodation that will enable you to perform each of the essential functions of your job. In accordance with the Americans with Disabilities Act (ADA), it is our policy to provide reasonable accommodations, where possible, for our employees with disabilities. A reasonable accommodation is one that will enable an employee to perform the essential functions of their position without imposing an undue hardship on the employer.

We cannot provide you with an accommodation without your help. Therefore, we need you to give us specific information pertaining to your condition and the accommodation you are requesting. Keep in mind that any information you give us regarding your medical condition will be kept in a confidential medical file. Access to this file will be limited to only those with a need to know.

Please answer the following questions, giving as much detail as possible. Once we receive the information we need, we will be able to work with you to determine whether an accommodation is possible.

1. Please identify and describe the nature of the disability or medical condition that requires the requested accommodation.

2. Please identify and describe what essential function(s) of your job are affected by your disability or medical condition.

3. Please identify and describe the accommodation you are requesting.

4. Please describe how the accommodation you are requesting will enable you to perform the essential function(s) of your job that have been affected by your disability or medical condition.

5. Please identify and describe any ways in which your ability to perform the essential functions of your job will be impaired, even with the requested accommodation.

6. Please identify and describe any known costs associated with your requested accommodation.

7. Please provide us with a completed Physician Accommodation Questionnaire from your physician (the Questionnaire is attached to this form).

Please note that simply completing this form does not mean we can or will provide the accommodation you are requesting, nor does it mean this is the only information we will need to evaluate your request. However, it is the essential first step in determining whether we can provide you with an accommodation.

Once we receive the information listed in this Request, we will schedule a time to review your condition and our options. Failure to provide the information requested in this form may prevent us from providing you with a reasonable accommodation.

Date Submitted:	Signature:

Reviewed by:	Date:

PHYSICIAN QUESTIONNAIRE

Name of Patient/Employee:	

Current Position:	

* * * * * * * * * * * * * *

_____ , your patient (our employee), is in the process of requesting an accommodation in the workplace to help him or her to perform each of the essential functions of his or her job. In accordance with the Americans with Disabilities Act (ADA), it is our policy to provide reasonable accommodations, where possible, for our employees with disabilities.

In order for us to determine what accommodations may be possible, we are asking that you provide us with some basic information concerning the employee's medical condition and related restrictions, as well as any suggestions you may have regarding possible accommodations.

Ultimately, we are hoping we can work with the employee to reasonably remove any barriers that may be preventing him or her from performing the essential functions of the job. Thank you for taking the time to help us figure out what we can do for our employee.

1. Describe the nature of the disability or medical condition.
   _____

2. What is the expected duration of the disability or medical condition?
   _____
   _____

3. Describe in detail how the disability or medical condition limits or affects the employee in one or more ***major life activities***.
   _____

4. Does the disability or medical condition pose a ***direct threat*** to the employee or others in the workplace?

   _____

5. Please describe in detail any work restrictions and/or how the disability or medical condition may otherwise affect the employee's ability to perform the functions of his or her job.

   _____
   _____

Taking into account the restrictions and limitations discussed above, describe any ***reasonable accommodation(s)*** that you believe would allow the employee to perform the functions of his or her job including reasonable accommodations that would eliminate a direct threat to the employee or others in the workplace. If you recommend a leave of absence, please provide the duration of leave requested, the estimated date you expect the employee to return to work, and the anticipated work restrictions, if any, upon the employee's return.

_____
_____

_____

Name (printed:)	
Date:	Signature:
Health System/Clinic:	