

ADA Accommodation forms

Employee Request for Reasonable Accommodation

Request for Information from Medical Provider



Employee Request for Reasonable Accommodation

Date of Request: _____

Employee Name

Employee Contact Number

Job Title

Site Location

This information will be used by the Boise School District or any other person, including the school district's legal counsel, who is authorized by my employer to handle medical information for ADA purposes and, any information concerning my physical or mental condition, that are necessary to determine whether I have a disability as defined by the Americans with Disabilities Act and to determine whether any reasonable accommodations can be made. The provision of this information is voluntary. Please note that your request cannot be process unless all sections of this form are completed.

What is the accommodation you are requesting? Please be as specific as possible.

Is your request time sensitive? Yes No

What limitation or condition is interfering with your ability to perform your job?

What job function or task are you having difficulty performing?

Explain or identify (if any), an employment opportunity, benefit, or privilege that you are having difficulty accessing?

How will the requested accommodation assist you?

Please provide any other information you think would be useful in evaluating your request.

I understand that all information obtained by my employer during this process will be maintained and used in compliance with ADA confidentiality requirements. I also understand that I may be required to provide my employer with medical documentation about my condition, its functional limitations, and appropriate accommodations. I authorize my treating provider to communicate with and provide information to the Independent School District of Boise City for the purpose of determining a reasonable accommodation to enable me to perform the essential functions of my job. I understand that I will still be held accountable for complying with all of the school district's policies and performance expectations as they relate to my job.

Employee's Signature

Date

Request for Information from Medical Provider

To the Provider: The Independent School District of Boise City employee named above (your "Patient") is requesting an accommodation due to a claimed physical or mental impairment that substantially limits one or more major life activities. When considering such accommodation requests under the Americans with Disabilities ADA (ADA) an employee's attending healthcare provider is allowed to offer his/her professional opinion regarding the nature and extent of the claimed impairment. To be considered, this Healthcare Provider's Statement must be based on clinical information and diagnosis that is current within six (6) months of the date of the accommodation request. In response to that request, we are seeking specific information as detailed below. Please provide the requested information only—**please do not send copies of medical records.**

Patient/Employee Name _____

1. Does the employee have a physical or mental impairment?

Yes No

2. What is the impairment?

3. What is the expected duration of the impairment? _____

Permanent

Temporary (please explain)

Chronic (please explain)

Episodic (please explain)

4. Does the impairment affect a major life activity?

(Examples of major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and the operation of a major bodily function such as the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive systems.)

Yes No

5. Does the impairment *substantially limit* one or more major life activity?

Yes No

6. Does the employee have any functional limitations resulting from the impairment?
Please describe:

7. Please refer to the attached description of the employee's job that contains a list of essential job functions. How does the functional limitation described in #6 above impact the employee's ability to perform the essential functions of his or her job?

8. Do you have any suggestions for possible accommodations that will enable the employee to perform the essential functions of the job? Please describe:

9. How would your suggested accommodation(s) enable the employee to perform the essential functions?

Attestation by Health Care Provider:

Name of Treating Healthcare Provider: _____

Provider's Signature _____

Contact office phone number and Fax _____

Date: _____

Return this information marked confidential to the attention:

Maria Rella, Human Resources Manager, Independent School District of Boise City
8169 W. Victory Road
Boise, ID 83709
Direct work number: 854-4070
Confidential Fax to: 854-4010