TULSA PUBLIC SCHOOLS

# Reasonable Accommodation Request Form

**Purpose of this form:** This form is for Team Tulsa members who need a workplace accommodation for their own disability. The purpose of this form is to document the employee's request for accommodation and to facilitate obtaining input (if needed) from a health care professional regarding the existence of a disability, whether an accommodation is needed, and, if so, what accommodation(s) would be effective to enable the employee to work.

This form will be used as part of an interactive process between the district and the employee to determine what, if any, accommodations will be provided to the employee. Both the district and the employee have an obligation to engage in the interactive process. At any point in the process, Talent Management and/or your supervisor may reach out to you to discuss your request. We will be unable to act on your request without your participation and cooperation in this process.

**Instructions: Part I** of this form is to be completed by the employee. **Part II** is to be completed by the Talent Strategist (for school-based roles) or the Employee Relations Manager (for non-school-based roles). Both Part I and Part II, together with a copy of the employee's job description, are to be provided to a healthcare or rehabilitation professional, who will complete **Part III**. Once **Part III** is completed, the employee should return the form directly to the Talent Strategist (for school-based roles) or the Employee Relations Manager (for non-school-based roles).

**IMPORTANT: THIS FORM AND ANY ACCOMPANYING DOCUMENTATION WILL BE MAINTAINED CONFIDENTIALLY AND SEPARATELY FROM THE EMPLOYEE'S REGULAR PERSONNEL FILE.**

## PART I. ACCOMMODATION REQUEST

(TO BE COMPLETED BY THE EMPLOYEE)

Employee Name: _____ Employee ID: _____

Job Title/Assignment: _____ Location/Dept: _____

Employee Cell/Home Phone: _____ Employee Email: _____

Supervisor Name: _____

1. Is the reason you need an accommodation related to COVID-19? ____ Yes ____ No

2. If you answered "yes" to question 1, are you fully vaccinated against COVID-19? ____ Yes ____ No

3. If you answered "no" to question 2, please state the reason(s) you are not fully vaccinated against COVID-19:

_____

_____



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4. Please describe the reason(s) you need a workplace accommodation (i.e., identify the nature of your physical or mental impairment). If you are requesting an accommodation because you have a condition that may place you at increased risk for severe illness if you contract COVID-19, identify the condition.*

_____

_____

5. Please explain how your physical or mental impairment impairs or limits you at work (i.e., why do you need a workplace accommodation). (You do **not** need to answer this question if the only reason for your request is that you have a condition that places you at increased risk for severe illness for COVID-19.)

_____

_____

6. What accommodation(s) are you requesting, if known? (If leave is your requested accommodation, please write "leave" below. Please note that, while all requests will be considered, the district generally does not consider telework to be a reasonable accommodation for school-based roles. Also, if multiple accommodations would work for you, please list all of them and note your preference.)

_____

_____

7. How would your requested accommodation(s) enable you to perform your job or continue working?)

_____

_____

8. If you are not sure what accommodation(s) you need, do you have any suggestions about what options we can explore?

_____

_____

9. Please provide any additional information that might be useful in processing your accommodation request:

_____

_____

_____

_____ _____

**Employee Signature** **Date**



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****WHEN COMPLETED, EMPLOYEE MUST RETURN THIS FORM TO TALENT STRATEGIST OR SUPERVISOR.**

## PART II. INSTRUCTIONS TO HEALTHCARE OR REHABILITATION PROFESSIONAL

(TO BE COMPLETED BY TALENT STRATEGIST/EMPLOYEE RELATIONS MANAGER)

### Instructions to Healthcare or Rehabilitation Professional Completing this Form

Dear Healthcare or Rehabilitation Professional,

Your patient, _____, is one of our valued team members. They are requesting a workplace accommodation (see Part I above). We are asking you to complete this form to help us confirm:

| | |
|---|---|
| | **Part III.A below** - Whether your patient has a condition that can place them at increased risk for severe illness from COVID-19 |
| | **Part III.B below** - Whether your patient has an ADA-covered disability (one that substantially limits them in one or more major life activities) |
| | **Part III.C below** - Whether your patient needs an accommodation at work because of a condition identified in **Part III.A** or an impairment identified in **Part III.B** and, if so, what accommodation(s) would be effective for your patient (i.e., enable them work) |
| | A copy of the employee's job description is attached to assist you in understanding the essential functions of your patient's job. |
| | An overview of the health and safety measures we have put in place to keep our staff, students and families as safe as possible from COVID-19 is attached. |

**Note:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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**PART III. EXISTENCE OF DISABILITY/NEED FOR ACCOMMODATION**
(TO BE COMPLETED BY HEALTHCARE OR REHABILITATION PROFESSIONAL – ATTACH EXTRA PAGES IF NEEDED)

**Part A. Is the employee at increased risk for serious illness if they contract COVID-19?**

1. Does the employee have one or more of the following impairments/conditions? (Check all that apply)

__ Cancer
    __ Currently has cancer
    __ Has history of cancer
__ Chronic kidney disease
__ Chronic lung diseases:
__ COPD/emphysema/chronic bronchitis
__ Asthma
    Is the patient's asthma moderate-to-severe? __ Yes __ No
__ Damaged/scarred lung tissue (such as interstitial lung disease, idiopathic pulmonary fibrosis)
__ Cystic fibrosis
__ Pulmonary hypertension
__ Dementia or other neurological conditions
__ Diabetes (type 1 or type 2)
__ Down syndrome
__ Heart conditions (such as heart failure, coronary artery disease, cardiomyopathies or hypertension)
__ HIV infection
__ Immunocompromised state (weakened immune system)
__ Liver disease
__ Overweight and Obesity
    __ Overweight (defined as a body mass index (BMI) > 25 kg/m2 but < 30 kg/m2)
    __ Obesity (BMI ≥30 kg/m2 but < 40 kg/m2)
        __ Does the patient's obesity result from an underlying physiological condition? __ Yes __ No
        If yes, specify: _____
    __ Severe obesity (BMI of ≥40 kg/m2)
        __ Does the patient's obesity result from an underlying physiological condition? __ Yes __ No
        If yes, specify: _____
__ Pregnancy
__ Recent pregnancy (must be within last 42 days; state date pregnancy ended: _____)
__ Sickle cell disease or thalassemia
__ Hemoglobin blood disorders (sickle cell disease (SCD) or thalassemia )
__ Solid organ or blood stem cell transplant
__ Stroke or cerebrovascular disease, which affects blood flow to the brain
__ Substance use disorder



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**Part B. Does the employee have an ADA-covered disability?**

1. Does the employee have a physical or mental impairment? ____ Yes ____ No

2. Please describe the nature of the employee's impairment/condition (including anticipated duration):

_____

_____

_____

_____

3. Please answer the following questions based on what limitations the employee has **when the employee's impairment is in an active state** and **if no mitigating measures are used**. (Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.)

   a. Does the employee's impairment substantially limit a major life activity (including major bodily functions) as compared to most people in the general population? ____ Yes ____ No
   **OR**
   Describe the employee's limitations when the impairment is active:

_____

_____

_____

   b. If applicable, check any major life activity(ies) that is/are substantially limited by the employee's impairment:

| | | |
|---|---|---|
| __ Bending | __ Breathing | __ Caring for self |
| __ Concentrating | __ Eating | __ Hearing |
| __ Interacting with others | __ Learning | __ Lifting |
| __ Performing manual tasks | __ Reaching | __ Reading |
| __ Seeing | __ Sitting | __ Sleeping |
| __ Speaking | __ Standing | __ Thinking |
| __ Walking | __ Working | __ Other: _____ |



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c. If applicable, check any major bodily functions that are substantially limited by the employee's impairment:

| | | | | | |
|---|---|---|---|---|---|
| __ | Bladder | __ | Bowel | __ | Brain |
| __ | Cardiovascular | __ | Circulatory | __ | Digestive |
| __ | Endocrine | __ | Genitourinary | __ | Hemic |
| __ | Immune | __ | Lymphatic | __ | Musculoskeletal |
| __ | Neurological | __ | Normal cell growth | __ | Operation of an organ |
| __ | Reproductive | __ | Respiratory | __ | Special sense organs & skin |

__ Other: _____

d. If applicable, please explain how the individual's impairment substantially limits any major life activity or major bodily function identified above:

_____

_____

_____

_____

**Part C. What (if any) accommodation(s) are needed and would be effective to allow the employee to work?**

1. Please explain the difficulty the employee is experiencing at work because of the impairment identified. (If the only "difficulty" the employee is experiencing is that they are at increased risk for serious illness if they contract COVID-19, you may respond simply by saying "Increased Risk for COVID-19.")

_____

_____

_____

_____



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2. **If the employee requested a specific accommodation in Part I above**, would that accommodation be effective to address the difficulty(ies) they are having at work? ____ Yes _____No. Please explain why or why not below. (If the employee is requesting leave as their preferred form of accommodation, please put "N/A" below).

_____

_____

_____

_____

3. Sometimes the employee's preferred/requested form of accommodation is not reasonable or possible, and when multiple effective options are available Tulsa Public Schools will consider the employee's preferences but ultimately may choose to provide a different form of accommodation. What accommodation(s) **other than any that the employee has specifically requested/identified in Part I** do you believe are needed and would be effective to address the difficulty(ies) the employee is having at work/enable the employee to continue working? **If the employee is requesting telework**, are there any other accommodations available that would enable the employee to continue working on-site?

_____

_____

_____

_____

_____

4. **If the reason for the employee's request is that they have a condition that can cause them to be at increased risk for COVID-19:** If the employee is vaccinated, please explain whether/why the employee is still at significant increased risk and help us understand the level of risk; if the employee is not vaccinated, please describe any medical reason the employee is unvaccinated:

_____

_____

_____

_____



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5. **If the employee is asking for an accommodation re: masking for COVID-19:** Please describe the extent to which the employee can wear a mask at work. If the employee must work with a face covering to reduce COVID-19 risks but has difficulty wearing a mask, are there any accommodations that could be provided that would enable the employee to wear a mask (e.g., more frequent breaks)?

_____

_____

_____

_____

6. Please offer any other comments/suggestions you may have regarding accommodations needed by the employee:

_____

_____

_____

_____

**Healthcare or Rehabilitation Professional's Name & Specialty:**

_____

**Healthcare or Rehabilitation Professional's Address:**

_____

_____

_____
**Healthcare or Rehabilitation Professional's Signature**

_____
**Date**

****WHEN COMPLETED, EMPLOYEE MUST RETURN THIS FORM TO TALENT STRATEGIST OR SUPERVISOR.**

**To be completed by Talent Management:**

Received from employee on: _____ [DATE]  Decision made on _____ [DATE]



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