CONFIDENTIAL

REQUEST FOR ACCOMMODATION

Appendix A Completed by Employee

Please complete this form if you have a physical or mental health disability and need a reasonable accommodation to perform the essential functions of your position or to participate in the hiring process. This form should be returned directly to ***Human Resources****.* ***FOR CURRENT EMPLOYEES, THIS FORM SHOULD NOT BE RETURNED TO YOUR MANAGER OR TO ANYONE AT YOUR LOCATION.***

Employee's Name:_____ **B#** _____

School/Department: _____

Supervisor:_____ **Position title:** _____

Current status: Active (at work) ☐ **Leave of Absence** ☐ Expires:_____

1. List Impairment(s):
2. Specify how the impairment(s) listed above affect your ability to perform the essential functions of your job:
3. List job specific accommodation(s) requested to enable you to perform the essential functions of your job:
4. Is your impairment ☐ **Permanent** ☐ **Temporary** ☐ **Unknown** **If temporary, anticipated date accommodation(s) no longer needed:** _____

NOTE: Attach any supporting documentation that may be helpful in evaluating this request for accommodation. A physician statement or other relevant medical report outlining condition, limitations, and accommodations may be requested, if needed, for the District to consider this accommodation request. If you are seeking an accommodation that is medically necessary, please provide Attachments B & C to your physician.

I certify that the information contained and submitted with this form is true and correct.

Signature: _____ Date: _____

MEDICAL INFORMATION
(ATTACHMENT B)

Dear Healthcare Provider:

Your patient _____ is currently employed by the Madison Metropolitan School District and has requested ADA accommodations. Employees who request accommodations are asked to provide medical documentation from their healthcare provider that describes their medical condition and describes any limitations placed on their major life activities and functions.

This request for medical information is being made to help the Madison Metropolitan School District review this request for accommodation, engage in the interactive process with the employee, and make a determination. Please review the standards for the medical documentation information listed below so that your patient's request can be reviewed in an efficient and thorough manner.

Medical information to be provided by a qualified health care professional and attached to the Request for ADA Reasonable Accommodation Form:

1. Include a statement of the specific diagnosis of the disability.

2. Cite the diagnostic criteria and tests given, with dates (no more than 3 years since administration) results, and interpretations. Cite how the results support the diagnosis.

3. Describe the applicant's functional limitations due to the disability, and the impact of those limitations on physical, perceptual and cognitive abilities.

4. Recommend specific accommodation(s) and for each accommodation, provide a rationale as to how it will reduce the impact of the functional limitation(s).

5. State your professional credentials and any licenses you hold that support your qualifications to diagnose and/or treat this applicant's disabilities.

6. Send Documents to:
   Human Resources
   Madison Metropolitan School District
   545 W. Dayton
   Madison,WI 53703
   By email: lmmortenson@madison.k12.wi.us
   By Fax: (608-204-0346)

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.

MADISON METROPOLITAN SCHOOL DISTRICT
MEDICAL CERTIFICATION
Attachment C

Directions: Employees should complete the Employee Information section, and sign below. The healthcare provider completes the remainder of the form. Please return to **Human Resources at (lmmortenson@madison.k12.wi.us), or via Fax to 608-204-0346 or by mail to:**

Human Resources
Madison Metropolitan School District
545 W. Dayton Street Room 133
Madison WI 53703.

EMPLOYER INFORMATION	
Madison Metropolitan School District	Phone: 608-663-1742
545 W Dayton Street, Room 133, Madison, WI 53703	Fax: 608-204-0346

EMPLOYEE INFORMATION (to be completed by the employee)	
Name	B Number
Assignment	Location
Home/Cell Phone	Email

The employee named above hereby authorizes the healthcare provider to complete the form below and submit supporting documentation to the Madison Metropolitan School District for the purposes of reviewing the employee's request for reasonable accommodation.

CERTIFICATION OF PHYSICAL DISABILITY/MEDICAL CONDITION

Please take into consideration when completing this form:

1. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting may delay the eligibility review process by necessitating follow up contact for clarification.
2. The healthcare provider should attach any reports which provide additional related information. If a comprehensive diagnosis report is available that provides the requested information; copies of that report can be submitted for documentation as well.

Employee Signature: _____ Date: _____

Does the employee have a physical or mental impairment?	Yes ☐ Date of Diagnosis_____	No ☐

What is the diagnosis of the impairment? (Please use definitive language and avoid such speculative language as "suggests" or "could have problems")

If applicable, how much leave will the employee likely need? (e.g., 3 weeks, half a day every other week, as needed but approximately three consecutive days each month).

What are the approximate dates the leave will be needed?

Does the impairment substantially limit a major life activity as compared to most people in the general population? ***Note:*** *Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.*	Yes ☐	No ☐

If yes, what major life activity(s) (includes major bodily functions) is/are affected?

❑ Bending	❑ Hearing	❑ Reaching	❑ Speaking	❑ Other: (describe)
❑ Breathing	❑ Interacting with others	❑ Reading	❑ Standing	
❑ Caring for Self	❑ Learning	❑ Seeing	❑ Thinking	
❑ Concentrating	❑ Lifting	❑ Sitting	❑ Walking	
❑ Eating	❑ Performing Manual Tasks	❑ Sleeping	❑ Working	

How does this condition/impairment impact the employee's ability to perform his/her job? If this condition/impairment does not affect the employee's ability to work, please explain.

If the employee is currently undergoing medical treatment, please describe and indicate how this treatment might affect the employee's work.

Are there any situations that might lead to an exacerbation of the condition/impairment?

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The employer may choose among effective accommodation options. The following questions may help determine effective options:

1. If a leave of absence is suggested, is there a possibility the employee could work if accommodations were provided other than leave?

2. If yes, what accommodations would you suggest?

   a.

   b.

   c.

3. How would your suggestions improve the employee's job performance?

   a.

   b.

   c.

Provide additional comments that would be useful in the accommodation process:	
Medical Professional's Signature	Date
Address	City State Zip
Phone	Email

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