Madison Metropolitan School District

Request for Accommodation

Instructions and Documents

INSTRUCTIONS:

PROCEDURE FOR REQUESTING AN ADA REASONABLE ACCOMMODATION

1. Follow the steps below to initiate the process.

   a. The employee completes an ADA Reasonable Accommodation Request Form (Attachment A).

   b. The employee gives the Medical Information memo (Attachment B) and the Certification of Physical Disability/Medical Condition Form (Attachment C) to their physician who, in tum, will provide the required medical information. Submit Attachment B, along with a copy of your job description, and a copy of this letter to your health care provider.

   c. The employee then submits the ADA Reasonable Accommodation Request Form to the Human Resources Department.
   The Certification of Physical Disability/Medical Condition form and any additional medical information (records) should be submitted by the employee or medical provider to the Human Resources Department for a reasonable accommodation review. Documents should be sent to:

   Human Resources
   Madison Metropolitan School District
   545 W. Dayton
   Madison,WI 53703
   (tacaradine@madison.k12.wi.us)
   (608-204-0346)

   d. If you have any additional questions regarding the ADA Reasonable Accommodation application process, please contact: Tracey Caradine, Director of Employee Relations.

An accommodation that is medically necessary is one that has a risk-avoiding or therapeutic value associated with the accommodation and will enable the employee to perform the essential functions of their job. On the other hand, if the review concludes that, based upon the accommodation assessment of the employee's medical information, an accommodation is not medically necessary or is not likely to be effective, the request for the accommodation may be denied.

MEDICAL INFORMATION
(ATTACHMENT B)

Dear Health Care Provider:

Your patient _____ is currently employed by the Madison Metropolitan School District. Employees who request accommodations are asked to provide medical information from their medical doctor 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 because your patient has applied for an ADA reasonable accommodation. Please review the standards for the medical documentation information review 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 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
   (tacaradine@madison.k12.wi.us)
   (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.

CONFIDENTIAL

REQUEST FOR ACCOMMODATION

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 on this form and submitted with this form is true and correct.

Signature: _____ Date: _____

MADISON METROPOLITAN SCHOOL DISTRICT
ADA REASONABLE ACCOMMODATION REQUEST FORM & DOCTOR CERTIFICATION

Health & Safety Mitigation Strategies

MMSD has taken the health & safety of all staff and students seriously. Engaging in in-person learning while the virus causing COVID-19 remains in circulation with no vaccine available requires thoughtful considerations and carefully detailed planning. The following health & safety mitigation strategies are enforced across the school district:

-6 foot social distancing within all classrooms and workspaces. Desks and workspaces will be no closer than 6 feet apart.
-Plexi-glass barriers installed and available when social distancing is limited.
-Hallway traffic patterns to ensure social distancing is maintained.
-All staff and students are required to wear masks (2-layer cloth masks are mandated) and additional PPE provided to medical personnel.
-Frequent hand washing as well as hand-sanitizer stations available throughout buildings.
-Frequent high-touch cleaning as well as nightly deep cleaning protocols.
-Daily symptom screening completed by staff and students prior to entering buildings. If staff/students exhibit any symptoms, they are unable to enter the building.
-Contact tracing completed by district trained nurses in the event a staff or student tests positive for COVID.
-Health & safety training is completed by all staff, including cough and sneeze etiquette.

Directions: Employees should complete the Employee Information section and the healthcare provider completes the remainder of the form. Please return to **Human Resources at (tacaradine@madison.k12.wi.us)**.

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	
Home/Cell Phone	
B Number	

ACCOMMODATION INFORMATION (The treating licensed medical provider should complete the section below to identify the accommodations needed for the employee to work)			
Diagnosis			
Accommodation	The accommodations listed below are: ☐ **Preferred for in-person instruction** ☐ **Required for in-person instruction** ☐ **Full duty with the mitigation strategies referenced above** as of _____(date) ☐ **Full duty with the mitigation strategies referenced above** as of _____(date) **AND:** Additional PPE (examples include a face shield, surgical mask, gown). Please list the additional PPE: _____ Other. Please list below: _____ ☐ **Other**_____ through _____(date) Comments:		
Physician Name		Facility Name	
Facility Address		Facility Phone Number	
Physician Signature		Date	

CERTIFICATION OF PHYSICAL DISABILITY/MEDICAL CONDITION
(ATTACHMENT C)

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.

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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