GAINESVILLE CITY SCHOOL SYSTEM

EMPLOYEE REQUEST FOR ACCOMMODATIONS ON THE BASIS OF MEDICAL IMPAIRMENT

I, _____wish to request accommodations on the basis of a medical impairment. My medical condition(s) is (are): _____
_____.
I am limited in my ability to: _____
_____.
The accommodation(s) that I am requesting is (are): _____
_____.
The expected duration of the need for the accommodation(s) is: _____
_____.

Name of Health Care Provider (1): _____
Health Care Provider's Address: _____
_____
Health Care Provider's Telephone No. : _____
Health Care Provider's Fax No. : _____

Name of Health Care Provider (2): _____
Health Care Provider's Address: _____
_____
Health Care Provider's Telephone No. : _____
Health Care Provider's Fax No. : _____

By affixing my signature below, I authorize the Gainesville City School System Human Resources Department, to confer with my health care provider and obtain medical records relative to the diagnosed condition(s) that has (have) given rise to the filing of this request for accommodations.

_____ _____
Employee's Signature Date

_____ _____
Position Work Location

Note to Employee: Complete all sections of this document and return it along with the completed Health Care Provider's Certification of Medical Impairment form to the Benefits Section of the Human Resources Department.

For Office Use Only

Received: _____