

MOUNT VERNON CITY SCHOOL DISTRICT

Request for Workplace Accommodation

***** Completed by Employee *****

Employee: _____

Date of Request: _____

Title: _____

Location: _____

Condition/limitation: _____

How does this condition/limitation affect your ability to perform the essential functions of your job?

Workplace accommodation(s) requested: _____

***** Completed by Employee's Physician *****

Physician (please print): _____

Date: _____

Physician Signature: _____

Telephone #: _____

Based on ADA criteria, please explain how/why the employee's condition/limitation constitutes a non-disqualifying disability (attach additional pages as needed):

Please identify the workplace accommodations that are either recommended or required for the employee to be able to perform the essential functions of his/her job (attach additional pages as needed):

Accommodation(s)	Recommended or Required
	<input type="checkbox"/> Recommended <input type="checkbox"/> Required
	<input type="checkbox"/> Recommended <input type="checkbox"/> Required
	<input type="checkbox"/> Recommended <input type="checkbox"/> Required

Return this form to the Human Resource Office with any additional supporting documentation