



School District of the City of Pontiac

Human Resources Office | Y'londa Kellum, Assistant Superintendent of Human Resources

DISABILITY ACCOMMODATION REQUEST FORM

Part 1: To be completed by employee and employee's healthcare provider

Employee Name: _____ Date of Request: _____

Email Address: _____ Telephone Number: _____

It has been indicated that you may require an adjustment or change at work for a reason related to a medical condition, commonly referred to as a reasonable accommodation. To qualify, you must:

- (i) have a "disability" as defined under applicable law, and
- (ii) request that the Company provide you with a reasonable accommodation.

If you would like to request such an accommodation, we will need you to provide the following information. Further, your healthcare provider ("HCP") will need to complete questions 4-8 posed below in order to consider and evaluate your request.

1. Please describe the nature of your disability as defined by the American with Disabilities Act and/or its amendment(s). Information may be found at: <http://www.dol.gov/dol/topic/disability/ada.htm>.

2. Please describe the Pontiac Schools job function that your disability prevents you from doing.

3. Please description the work accommodation you are requesting. If you are requesting more than one possible accommodation, please list each requested accommodation individually. (Job accommodations could include, for example, additional leave, reduced hours of work, lifting restrictions and similar job modifications).



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4. A HCP assessment as to whether your impairment(s) substantially limit(s) any major life activities, and if so, which ones and how.

5. A HCP's assessment of the extent to which your impairment(s) currently limit your ability to perform the regular work activities and essential functions of your position;

6. A HCP's assessment as to whether your impairment(s) necessitate any accommodations to allow you to perform the regular work activities and essential functions of your position;

7. A HCP's assessment as to what accommodations would allow you to perform the essential functions of your position; and

8. A HCP's estimate of the approximate date you will be able to return to work if you are out on a continuous basis or how long a requested accommodation should be in effect. If more than one accommodation is requested, the estimated duration of each accommodation must be identified.

Employee Signature: _____ Date: _____

Signature of Health Care Provider

Date

Provider's Name and business address:

Provider's Telephone Number:

Provider's Fax Number:



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Part 2: To be completed by the employer

1. Date discussed with employee: _____
2. Accommodations: approved as requested
 approved but different from the original request
 denied
3. Identify the accommodation provided:
4. If the approved accommodation is different from the one originally requested, explain the basis for denying the original request:
5. If an alternate accommodation was offered, indicate whether it was:
 accepted
 rejected
6. If it was rejected, state the basis for rejection:
7. If the accommodation is denied and no alternative accommodation was proposed, explain the basis for denying the request without an alternative accommodation:

Name: _____ Signature: _____ Date: _____

An individual who disagrees with the resolution of the request may ask the Superintendent of Schools to reconsider that decision within ten (10) business days of receiving this completed form with the Deciding Official's decision. Note that requesting reconsideration does not extend the time limits for initiating administrative, statutory, or collective bargaining claims.

If an individual is dissatisfied with the resolution and wishes to pursue administrative, statutory, or collective bargaining rights, they must take the following steps:
For an EEO complaint pursuant to 29 C.F.R. part 1614, contact an EEO counselor in the Office of Equal Opportunity within 45 days from the date of receipt of this form or a verbal response, whichever comes first.
For a collective bargaining claim, file a written grievance in accordance with the provisions of the collective bargaining agreement.