

**ADA: Request for Reasonable Accommodation Form**

Employee Name		Employee ID	
School/Location & Position		Supervisor	
<b>NATURE OF THE QUALIFYING DISABILITY</b> Please describe the nature, extent, and duration of your disability.			
<b>REQUESTED/ SUGGESTED ACCOMMODATION</b> Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job.			
<b>PHYSICIAN CONTACT INFORMATION</b> Please provide name, address, telephone and fax numbers. The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.			
I authorize the release of necessary confidential medical information regarding my disability to relevant supervisors as deemed necessary by Human Resources. I also attest to the fact that a copy of the position description has been given to me for review and reference.			
<b>Employee Signature</b>		Date	
<b>Chief/Director/ Principal/Supervisor Signature Required</b>		Date	
_____ Approve _____ Deny			
<b>HR Director Signature</b>		Date	
_____ Approve _____ Deny			
<b>Superintendent Signature</b>		Date	
_____ Approve _____ Deny			
These accommodations will be implemented and effective on _____ (date) and end on _____ (date). <b><u>Denial by Chief/Director/Principal/Supervisor must include detailed description of denial reasons.</u></b>			

*An Equal Opportunity Employer*

Dr. Edith Walker  
Superintendent

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