REASONABLE ACCOMMODATION REQUEST PHYSICIAN FORM

Dear Physician:

A request for a reasonable accommodation has been made by our employee, **[Employee's Name]**. To determine whether or not this request should be granted and how best to respond to this request, the Yellowstone School District is requesting that you complete the following form:

ADA Qualifying Disability
An employee has a disability if s/he has an impairment that substantially limits one or more major life activities or a record of such impairment.

1. Does the employee have a physical or mental impairment? (Includes any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.)
   ☐ Yes ☐ No

   If yes, specify the impairment:

2. Does the impairment substantially limit one or more major life activities or bodily functions?

   ☐ Yes ☐ No

   Check all that apply:

☐ Caring for oneself	☐ Performing manual tasks	☐ Hearing
☐ Seeing[1]	☐ Eating	☐ Sleeping
☐ Walking	☐Standing	☐ Lifting
☐ Bending	☐Speaking	☐ Breathing
☐ Learning	☐Reading	☐ Concentrating
☐ Communicating	☐ Working	☐ Operation of a major bodily function[2]
☐ Thinking	Other: _____	

[1] Do not check if this can be corrected through eye glasses or contact lenses
[2] Includes, but is not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions

Describe how the major life activity or operation of major bodily function is affected (do not take into account mitigating measures such as medication):

Determination of Reasonable Accommodation *(Answer only if the employee has a disability meeting the definition above)*

1. Please review the attached job description. Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?

   ☐ Yes ☐ No

   If yes, please continue to next question. If no, please list which job functions s/he is unable to perform and how long the employee will be unable to perform these job duties.

   Functions unable to perform:

   _____ # of weeks _____# of months _____permanently

2. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

3. The employee's typical schedule is 7:40 – 4:00, Monday - Thursday. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential job functions?

4. How would your suggestions improve the employee's job performance?

5. How long will the employee need the reasonable accommodation? If unable to provide a date, when will he or she be medically reevaluated?

Any additional comments or suggestions:

_____
Physician Name (Please Print)

_____ _____
Signature of physician completing form Date