



Request for Disability Accommodation Form

Aberdeen School District provides reasonable accommodation to individuals with disabilities as required by the Americans with Disabilities Act (ADA), upon request of the individual.

Please complete this form to request any type of accommodation for a physical or mental disability. Attach applicable medical documentation.

Aberdeen School District considers the following requests:

- For accommodations required to ensure equal opportunity in the hiring process.
- For accommodations that enable employees with disabilities to perform the essential functions of their job.
- For accommodations that enable employees with disabilities equal benefits and privileges of employment.

All information relating to requests for disability accommodation will be maintained by Human Resources, and are considered confidential medical records. As such, they will only be accessible to supervisors or managers, first aid personnel and government officials (regarding compliance with ADA, FMLA or other applicable laws) on a need-to-know basis.

NOTE: Aberdeen School District may require additional medical certification or information.

Employee Name

Date of Request

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Employment Status: ☐ Applicant ☐ Employee

Current Position and Department OR Position(s) Applied For

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Name of Direct Supervisor (for current employees only)

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Describe your disability (attach any available medical documentation):

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Describe the aspect of your disability that requires accommodation:

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Explain the accommodation you are requesting (actions, changes, equipment, etc.):

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Detail any resources you have, can access, or are aware of which would provide the requested accommodation:

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If medical documentation is not attached, please complete the following:

Name, Phone or Address of Primary Medical Practitioner or Physician

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Name, Phone or Address of Medical Specialist (if applicable)

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My signature constitutes permission for Aberdeen School District to contact the medical practitioner(s) listed above to release information applicable to my request for accommodation. I agree to complete any additional authorization forms required by the medical practitioner(s) for release of information. I certify that the information provided in this document is true to the best of my knowledge.

Employee Signature

Date

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Please attach additional pages if necessary. Please contact Human Resources with questions, and return this form to Human Resources upon completion.