THE AMERICANS WITH DISABILITIES ACT
REQUEST FOR ACCOMMODATION FORM

Title I of the American with Disabilities Act (ADA) prohibits employers covered under the ADA from discriminating against any qualified individual with a disability with respect to practically every aspect of the employment relationship, including job application procedures, hiring, advancement, discharge, compensation, job training, and other terms, conditions, and privileges of employment.

The Benefits Department facilitates the Benefits Review Committee, coordinating the use of internal and external resources to assist any employee who may be experiencing physical and/or mental health challenges which may affect the employee's job performance. The Benefits Review Committee reviews employees' requests for ADA accommodation and recommends appropriate and reasonable accommodations in accordance with the ADA.

Employee's Name: ____ EID#__________________

Address: ____

Phone Number: ________________________________

Social Security No. ________________________ Date of Birth: _________________ Gender: ________

School/Department: ____

Position Title:______________________________ Dept/Campus: _______________________________

Current status: □ Active □ Leave of Absence

Disability: ____

*The attached Health Care Provider Form must be completed by your physician and returned to **BenefitsReviewCommittee@dallasisd.org**.*

THE AMERICANS WITH DISABILITIES ACT

HEALTH CARE INFORMATION RELEASE FORM

The Benefits Department facilitates the Benefits Review Committee, coordinating the use of internal and external resources to assist any employee who may be experiencing physical and/or mental health challenges which may affect the employee's job performance. The Benefits Review Committee reviews employees' requests for ADA accommodations and recommends appropriate and reasonable accommodations in accordance with the ADA.

The employee's signature on this form authorizes written and verbal communications between the Benefits Review Committee facilitator named below and the health care professional(s). This communication will facilitate the analysis of reasonable and appropriate accommodation recommendations for the employee, and may be made by telephone, written correspondence, FAX, email or conferences. This is not a request for medical records.

ADA Advisory Committee Chair: Valerie Robertson, Director, HCM Benefits

----

I, ____, have read the above statement and I do hereby authorize the Dallas Independent School District's Americans With Disabilities Act Benefits Review Committee facilitator to communicate with the professional listed below by verbal or written correspondence; and I authorize both parties to share any information deemed necessary to facilitate the analysis of reasonable and appropriate accommodation recommendations.

Employee's Name _____________________________________ EID#: _____________________

Signature: ____ Date: _________________

Health Care Provider Name (please print) ____

(MD, DO, or Ph.D.)____

Address: ____

Phone: ______________________________ Email:____________________________________

HEALTH CARE PROVIDER FORM

Employee's Name: _____________________________________ EID#________________________

Diagnosis or nature of illness/injury: ____

Treatment prescribed, including frequency and duration: ______________________________________

THE AMERICANS WITH DISABILITIES ACT

How long will the employee need the accommodation(s): ______________________________________
(provide specific dates for the duration timeframe)

1) Is employee able to perform the job duties listed in the job description? _________________________

2) If there are any job duties the employee is unable to perform or can only perform in a limited manner, please list those job duties, describe any limitations and expected frequency and duration. ___

____

____

3) Are there any physical restrictions the employee must follow while at work? If so, please describe:

____

____

4) Are there accommodations that Dallas ISD will need to make to allow employee to perform the current job duties?

____

____

5) Can employee perform the essential functions of her job without being a “direct threat” to self or others? _______

6) How many hours per day can employee work? (if applicable) __________________________________

a. How many hours of sitting? (if applicable) ____

b. How many hours of standing? (if applicable) ____

c. How many days in a week? (if applicable)____

d. How many pounds can employee lift? (if applicable)___________________________________

Health Care Provider Name (please print) ____

(MD, DO, or Ph.D.)____

HCP License Number: ____

Address: ____

Phone: _____________________________ Email:____

Benefits
Human Capital Management

Signature: ____ Date: ___________________________

Please email completed ADA Accommodation Request Form, Health Care Provider Form, and Health Care Information Release Form to BenefitsReviewCommittee@dallasisd.org. Please call 972.925.4300 if you have questions or need assistance.