Mount Vernon City School District
165 North Columbus Avenue • Mount Vernon, NY • 10553 t 914-358-2350 • f 914-665-5596

Request for Workplace Accommodation

*** Completed by Employee ***

Employee: _____ Date of Request: _____

Title: _____ Location: _____

Condition/limitation: _____

How does this condition/limitation affect your ability to perform the essential functions of your job?

_____

_____

_____

Workplace accommodation(s) requested: _____

_____

_____

*** Completed by Employee's Physician ***

Physician (please print): _____ Date: _____

Physician Signature: _____ Telephone #: _____

Based on ADA criteria, please explain how/why the employee's condition/limitation constitutes a non-disqualifying disability (attach additional pages as needed):

_____

_____

_____

_____

Please identify the workplace accommodations that are either recommended or required for the employee to be able to perform the essential functions of his/her job (attach additional pages as needed):

Accommodation(s)	Recommended or Required
	☐ Recommended ☐ Required
	☐ Recommended ☐ Required
	☐ Recommended ☐ Required

Return this form to the Human Resource Office with any additional supporting documentation

REVISED 04/24