Human Resources Department
24411 Amador Street, Hayward, CA 94544 T 510.784.2600

REQUEST FOR REASONABLE ACCOMMODATION – MEDICAL PROVIDER

Employee's Name:	**Position:**

Instructions (to be completed by physician/psychiatrist: Please print or type)

The medical information below is requested by Hayward Unified School District so that the District may evaluate a request for reasonable accommodation made by the above employee/applicant under the Americans with Disabilities Act ("ADA") and related state law. The District seeks information to help determine whether the employee/applicant has a "covered disability" and the nature and extent of the employee/applicant's "functional limitations." Under the ADA, a "disability" is defined as "a physical or mental impairment which limits one or more major life activities." Examples of major life activities include performing manual tasks, walking, seeing, hearing, speaking, learning and working.

1. How long has the Employee been your patient?	2. Are you their regular medical provider?

3. Please **describe all functional limitations** that currently prevent the Employee from performing any of the duties listed on the attached job description. If no written job description has been provided, please base your discussion on your best understanding of the Employee's current job duties:

4. In your opinion, is the Employee able to perform their current job duties **with or without accommodation?**

5. During **what time period** have the functional limitations listed in your response to question number 3 existed for this Employee?

6. As best as you can, please describe specifically how these functional limitations prevent Employee from performing their duties:

7. In your opinion what **specific types of accommodations** (if any) might help the Employee perform the duties which they are currently unable to perform?

8. Please describe specifically **how** the accommodations you recommend (if any) would permit the Employee to perform duties they are currently unable to perform.

9. Please describe any functional limitations preventing the Employee from working either a full or reduced time schedule:

Additional comments:

MEDICAL FACILITY NAME (if applicable):	LOCATION:	CONTACT PHONE:
MEDICAL PROVIDER'S NAME (print):	SIGNATURE:	DATE: