CICERO PUBLIC SCHOOLS, DISTRICT 99
EMPLOYEE ACCOMMODATION REQUEST FORM

A. Personal Information:

Name:	Date:
Address:	Phone:
City:	State/Zip:
Employee ID Number:	Position:
Building:	Supervisor Name:

B. Medical Authorization:

By way of execution of this Confirmation of Accommodation Request Form, I hereby authorize the use and/or disclosure of my protected health information to the Human Resource Department of Cicero School District No. 99 (the District). I understand that I have a right to revoke this Consent, but that I must do so in writing to the attention of the Human Resource Department, 5110 W. 24th Street, Cicero, IL 60804.

- I understand that revocation is only effective after it is received and recorded by the District.
- I further understand that any use or disclosure made prior to the revocation under this Authorization will not be affected by a revocation.
- I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to federal privacy protection laws.
- I understand that my written authorization is not required for School District No. 99 to use my protected health information for treatment, payment and health care operations.
- I understand that I am entitled to receive a copy of this authorization and I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization.
- I understand that this Authorization will expire when my employment with School District No. 99 terminates, unless otherwise noted here_____(expiration date).
- I understand that if approved, the accommodations will be valid for one year. I understand that I will need to complete an accommodation request on an annual basis in order to continue the accommodations after the year has expired.
- I acknowledge that I have read the provisions in this Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

Signed:_____ Date: _____

Name (Print): _____

Personal Representative:
If a Personal Representative executes this form, that Representative warrants that he/she has the authority to sign this Authorization.

Signed:_____ Date: _____

C. Requested Accommodation:

In detail, the employee must explain the accommodation requested, in detail, in his/her own words. Such information must include the following:

1. any and all reasonable accommodations needed
2. the reasonable time period for the requested accommodation (e.g. July 1, 2020 through July 1, 2021)
3. the reason for the accommodation
4. an explanation of how the medical condition affects your ability to perform your job specifically including the essential function(s) of your job which you are unable to perform without reasonable accommodation(s)

Please also include the following when submitting your request to HR:

- the required physician certification form that was provided to you
- any other documents included to support your request

FOR HR USE ONLY:
Date this request was received by HR: _____