CICERO SCHOOL DISTRICT 99

5110 WEST 24TH STREET
Tel. (708) 863-4856

CICERO, ILLINOIS 60804
Fax (708) 416-1442

Date: _____

Dear Physician,

A request for an employment-related reasonable accommodation has been made by our employee _____. To assist us with this process, please complete the following questions below.

Please answer these questions to help determine disability and reasonable accommodation.

1) Please review the attached job description. (If no job description is attached, please discuss the position with our employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? ☐ Yes / ☐ No

If *yes,* please continue to next question.

If *no*, how long will the employee be unable to perform these job duties?

____ # of weeks ____# of months ____ permanently

2) Below please state and describe the employee's disability and/or physical and/or mental impairment that requires an accommodation and how it limits a major life activity.

3) What limitations are interfering with job performance, and how do they affect the employee's ability to perform the job functions?

4) What accommodations or adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

5) The employee's typical schedule is _____. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?

6) How would your suggestions improve the employee's job performance and/or assist the employee in performing their job?

7) How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?

7) To the best of your knowledge, has the employee had accommodations in the past for the same limitation(s)? If so, what were they and how did the accommodation(s) help the employee perform their job?

8) Is this accommodation request time sensitive? If so, please explain.

9) Please list any additional comments or suggestions below.

Physician Name (Please Print)	Telephone Number
Signature of physician completing form	Date