

**WALLER INDEPENDENT SCHOOL DISTRICT
EMPLOYEE REQUEST FOR ACCOMMODATION**

NAME

SCHOOL or DEPARTMENT

POSITION

EMPLOYEE ID

Identify your impairment(s) and indicate how you believe the impairment(s) affects your ability to perform your job duties:

State the accommodation(s) you believe are necessary to enable you to perform the essential functions of your job:

Provide the following information on the health care provider who will support your need for an accommodation, if requested. We may contact the health care provider to obtain information about your impairment and recommendations for accommodations. Please attach a copy of the Medical Release to this form.

Name _____

Address _____

Phone _____

Fax Number _____

Signature of Requestor

Date of Request

**RETURN THIS REQUEST TO
ANGIE CAMPBELL PULIDO, CHIEF HUMAN RESOURCES OFFICER
WALLER ISD
2214 WALLER STREET
WALLER, TEXAS 77484
(936) 931-0371**