GLTS
Greater Lawrence Technical School

REASONABLE ACCOMODATION REQUEST FORM

Name: _____

Address: _____
Street Apt. # City State Zip

Telephone: _____ Email: _____

REQUEST FOR REASONABLE ACCOMODATION

1. I am requesting accommodation because (circle one): **A or B**

(A) I am applying for employment. The accommodation requested will allow me to participate in the examination for (position title):

_____

(B) I am currently employed by Greater Lawrence Technical School and request a reasonable accommodation in order to perform essential functions of my position. My current job title is:

_____

2. I require an accommodation in order to perform the following essential function(s):
(Be specific. If the accommodation requires the purchase of equipment, please specify the model number, cost, source, etc.)

_____

_____

_____

3. Describe how this accommodation will assist you. **Please attach additional sheets as necessary.**

_____

_____

_____

Signature: _____ **Date:** _____

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REQUEST FOR MEDICAL INFORMATION FOR REASONABLE ACCOMODATION

Date:_____

To:_____
(Physician or Medical Provider)

Telephone:_____ Email:_____

RE: REQUEST FOR MEDICAL INFORMATION NEEDED TO ASSIST IN PROVIDING A REASONABLE ACCOMODATION FOR:

_____ _____ _____
(Applicant/Employee) **(Medical Record #)** **(Social Security #)**

Greater Lawrence Technical School has been asked to provide a reasonable accommodation to the employee listed above. The information requested below is confidential and will only be used to assess the individual's eligibility for an accommodation and the nature of any accommodation that might allow the employee to perform essential functions of his/her position. Please take the above definition into consideration and answer the following questions with respect to the employee's request for reasonable accommodation:

1. Does the individual have a physical or mental impairment that limits a major life activity? **YES**_____ **NO**_____
   If yes, please see the reverse side of this form to describe the limitation.
2. Is the disability permanent? **YES**_____ **NO**_____**.** Length of anticipated duration:_____
3. From the enclosed job description, specify any job duties that the employee cannot perform because of his/her physical or mental impairment:

   _____

   _____
4. How do the impairments listed above impair the ability of the employee to perform the job duty described above?

   _____

   _____

Under the Americans with Disabilities Act, an ***individual with a disability*** is a person who:
(1) Has a physical or mental impairment that substantially limits one or more major life activities (major life activity may include walking, breathing, speaking, performing manual task, seeing, hearing, learning, caring for oneself, sitting, standing, lifting, or reading); (2) Has a record of such an impairment; or (3) Is regarded as having such an impairment.

PHYSICIAN'S SIGNATURE_____ **DATE**_____

PHONE_____

Instructions: Complete this side of the form only if the answer to question #1 is yes.

_____	_____	_____
(Applicant/Employee)	**(Medical Record #)**	**(Social Security #)**

Work Restrictions: Patient is restricted from or limited in performing the following functions (check activity and enter limitation, i.e.: 0 hours; 1-2 hours, 2-5 hours; 6-8 hours; or other notation.)	
☐ KEYBOARD USE/REPETITIVE USE OF HANDS	☐ GRASP/FINE FINGER MOTIONS
☐ SIT	☐ REPETITIVE USE OF FOOT CONTROLS
☐ STAND	☐ WALK
☐ SQUAT/KNEEL	☐ TWISTING (NECK/WAIST)
☐ BEND/STOOP	☐ CLIMB LADDERS/CLIMB STAIRS
☐ PUSH/PULL	☐ REACHING (Above and below shoulders)
☐ LIFT (Please specify lifting restrictions)	
☐ CARRY (Please specify carrying restrictions)	
☐ OTHER	

Describe any restrictions which may apply to the following:
☐ VISION
☐ HEARING
☐ MENTAL/EMOTIONAL
☐ OTHER (Sleeping, Speaking)

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize _____
(Name of employee) **(Name of health care provider)**

to release to Greater Lawrence Technical School medical information pertinent to the reasonable accommodation requested in the attached document.

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran Administration:

I authorize you to release to Greater Lawrence Technical School the above-requested information to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period of 180 days after the date of my signature or earlier if revoked by me in writing to Greater Lawrence Technical School. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

_____ _____
Employee Signature ***Date***