



Charles County Public Schools  
Office of Human Resources  
Employee Request for Accommodation

Charles County Public Schools (CCPS) provides reasonable accommodations for employees with sensory, mental, or physical disabilities. A reasonable accommodation under the Americans with Disabilities Act (ADA) is an accommodation that enables the employee to perform the essential functions of their position, is medically necessary, and does not create an undue hardship for the employer.

Please complete this request form and return it to the Office of Human Resources (OHR). **You are not required to disclose to your immediate supervisor the medical basis for a requested accommodation.** If more information is needed, the OHR may request that you ask your health care provider to confirm your disability and/or the need for the requested accommodation. **It is your responsibility to see that your health care provider completes and returns the “Employee Restrictions and Limitations (REV 6/22/2020)” to the Employee Benefits Department.** If more specific information is needed to respond to your request, a Job Analysis for your position may be prepared. A completed copy of the Job Analysis will be shared with you and your health care provider.

**An approved ADA accommodation is valid through the current school year of submission and must be resubmitted at the start of the next school year for evaluation.**

Eligible CCPS staff: certificated, non-certificated, CCPS contract staff, temporary staff [monthly or hourly paid], hourly paid student employees, and all other non-academic employees.

If you have questions regarding an accommodation, please contact the OHR at [accommodations@ccboe.com](mailto:accommodations@ccboe.com) or 301-934-7255, option #7.





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**ACCOMMODATION REQUEST FORM - PHYSICIAN**

**CONFIDENTIAL**

Charles County Public Schools requests that the treating physician(s) of \_\_\_\_\_  
*(employee's full name)*

provide information to enable the Office of Human Resources to assess whether there is a reasonable accommodation that we can provide to permit the employee to perform the essential functions of his/her position. **Please do not leave any area of this form blank. Mark "n/a" if not applicable.**

The CCPS employee has been advised that this form must be fully completed by you. If you have any questions, please contact the Office of Human Resources at (301)934-7255.

*List each medical condition(s)/diagnosis in which the employee is affected. (Please be as detailed as possible.)*

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*Is Employee substantially limited in any major life activities as a result of his/her health condition? If so, please be specific and identify the major life activities and limitation(s):*

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*Is Employee **unable to perform any of the essential functions** of his/her job as listed in the position description or limited in his/her ability to do so? If so, please identify each limitation or inability to perform and the expected duration.*

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*Does the condition cause Employee any functional limitations (such as limitations in the ability to reach, stand, bend, grip, concentrate, speak, etc.)? **If so, please describe the limitations, their expected duration, and recommended workplace accommodation.***

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**\*Please attach any additional information unable to be captured on this form.**

*(To be completed by treating physician only)*

Physician's Name \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Telephone number: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

Probable Duration of Condition: \_\_\_\_\_