



Dr. Edith M. Walker
Superintendent

Jared Bercegeay
President
District 6A

Marty J. Bourgeois
Vice President
District 4A

Robyn Penn Delaney
District 1

Willie Robinson
District 2

Julie Blouin
District 3

John Murphy
District 4B

John DeFrances
District 5A

Taft Kleinpeter
District 5B

Louis Lambert
District 6B

Karen Braud
District 7A

Jake Lambert
District 7B



Employee Name		Employee ID	
School/Location & Position		Supervisor	
NATURE OF THE QUALIFYING DISABILITY Please describe the nature, extent, and duration of your disability.			
REQUESTED/ SUGGESTED ACCOMMODATION Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job.			
PHYSICIAN CONTACT INFORMATION Please provide name, address, telephone and fax numbers. The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.			
I authorize the release of necessary confidential medical information regarding my disability to relevant supervisors as deemed necessary by Human Resources. I also attest to the fact that a copy of the position description has been given to me for review and reference.			
Employee Signature		Date	
Chief/Director/ Principal/Supervisor Signature Required ☐ Approve ☐ Deny		Date	
HR Director Signature ☐ Approve ☐ Deny		Date	
Superintendent Signature ☐ Approve ☐ Deny		Date	
These accommodations will be implemented and effective on _____ (date) and end on _____ (date). <u>Denial by Chief/Director/Principal/ Supervisor must include detailed description of denial reasons.</u>			

An Equal Opportunity Employer