CLINT INDEPENDENT SCHOOL DISTRICT DEPARTMENT OF

BENEFITS

Americans with Disabilities Act (ADA)
Request for Accommodation Medical Certification Form

CONFIDENTIAL pursuant to 29 C.F.R. § 1630.14

SECTION I: For Completion by the REQUESTING INDIVIDUAL

Name: _____ ____ _____
First MI Last

Job Position/Title: _____

Regular Work Schedule: _____

Nature of the Disability: (Briefly identify the nature, extent, and duration of your disability.)

Signature _____ Date _____

* **Note to Requestor**: Please find attached a copy of your job description.

SECTION II: For Completion by the HEALTH CARE PROVIDER

Instructions to the Physician

A request for a reasonable workplace accommodation has been made by the above-named individual. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine disability and reasonable accommodation.

Background

In accordance with the Americans with Disabilities Act (ADA), an individual has a disability if he or she has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such an impairment, or is regarded by others as having such an impairment.

The ADA provides examples of "major life activities" to include, but not be limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

SECTION II (cont.): For Completion by the HEALTH CARE PROVIDER

Provider Name: _____

Type of Practice / Medical Specialty: _____

Business Address: _____

Phone: _____ Email: _____

Fax: _____

Please answer the following in regard to the individual's identified disability:

1. Does the employee have a physical or mental impairment? ☐ Yes ☐ No
2. Please describe the employee's medical impairment or condition.

3. When did the medical impairment or condition begin?
4. How long is it expected to last?

5. Please describe the major life activities that are substantially limited by the medical impairment or condition or any accompanying treatment (e.g., breathing, eating, sleeping, walking, talking, manual tasks, operation of a major bodily function, etc.).

6a. Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties and typical schedule.) Is the employee able to perform the essential functions of this position in a typical schedule with, or without, reasonable accommodation?

☐ Yes, without reasonable accommodation ☐ Yes, with reasonable accommodation

☐ No, he/she is unable to perform the essential job functions with or without accommodation.

6b. If No, how long will the employee remain unable to perform these job functions?

_____ # of weeks _____ # of months ☐ Permanently

6c. If Yes, what adjustments to the work environment or position responsibilities would enable the individual to perform these job functions?

6d. If Yes, how long will the employee need the reasonable accommodation to perform these job functions?

_____# of weeks _____# of months ☐ Permanently

7. Additional Comments or Suggestions:

Healthcare Provider Signature: _____ **Date:** _____

When form is complete, please either:

1. Mail to Clint ISD, Attn: HR/Benefits Department, 14521 Horizon Blvd., El Paso, TX 79928
2. Email to valerie.martinez@clint.net; or
3. Fax to 915-926-4079.

If you have questions, please contact the Benefits Coordinator at 915-926-4073.