



San Benito Consolidated Independent School District
240 N. Crockett St. • San Benito, TX 78586 • Phone: (956) 361-6150

Employee 504 Accommodation Request

Employee Name: _____ Campus/Dept.: _____

Employee ID Number: _____ Job Title: _____

Is this an "on the job injury"? ☐ Yes ☐ No If yes, date of injury: _____

Note: Employee must provide a copy of their job description to their physician or healthcare provider.

This form must be filled out and signed by the employee's physician or healthcare provider.

Date disability began: _____

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

What is the diagnosis or impairment? _____

Is the impairment long-term? ☐ Yes ☐ No Is the impairment permanent? ☐ Yes ☐ No

If the impairment is not permanent, how long will the impairment likely last? _____

Does the impairment affect major life activities? ☐ Yes ☐ No

If yes, what major life activities are affected? (please check all that apply)

- | | | | | |
|------------------------------------|--|---------------------------------------|------------------------------------|---|
| ☐ Standing | ☐ Walking | ☐ Hearing | ☐ Working | ☐ Interacting with others |
| ☐ Seeing | ☐ Sleeping | ☐ Reaching | ☐ Speaking | ☐ Performing manual trades |
| ☐ Breathing | ☐ Thinking | ☐ Learning | ☐ Toileting | ☐ Caring for self |
| ☐ Sitting | ☐ Concentrating | ☐ Reproduction | | |

☐ Lifting (*indicate maximum safe limit in pounds and frequency*):

Pounds _____ Frequency _____

Other major life activities that are affected: _____

What limitation(s) is/are interfering with job performance? _____

What job function(s) is the employee having trouble performing because of the limitation(s)? _____

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)? _____

Do you have any suggestions regarding possible accommodations to improve job performance? ☐ Yes ☐ No

If yes, what are your suggestions? _____

How would your suggestions improve the employee's job performance? _____

Additional information: _____

Please feel free to attach a medical narrative.

Physician/healthcare provider's signature

Date

Physician/healthcare provider's name (*please print*)

Phone number

Address