

AMERICANS WITH DISABILITIES ACT (ADA) REASONABLE ACCOMMODATION REQUEST FORM

The purpose of this form is to assist Harrison School District Two in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

Instructions/Process:

- The employee must first complete Page 2 of this packet.
- The employee will then submit this packet to their medical professional, who will complete the remainder of the pages. The packet should include a copy of the employee's job description, which can be obtained from the Human Resources Department.
- The medical professional must sign and date the last page of this form.
- Upon receiving the completed packet from their medical professional, the employee will submit the packet to the District's ADA Compliance Officer.
- The completed packet will be reviewed by the District's ADA Compliance Officer. The ADA Compliance Officer will contact the employee and/or medical professional for any additional information or documentation needed, and consult with the employee's supervising administrator to determine reasonable accommodations.
- The ADA Compliance Officer will inform the employee and the employee's supervising administrator of any findings and/or approved accommodations.
- Questions regarding this process should be addressed to the ADA Compliance Officer, Katherine Ritchie-Rapp, at 719-538-1373 or kritchierapp@hsd2.org.

Information Pertaining to Medical Documentation:

In the context of assessing an accommodation request, medical documentation may be needed. Medical documentation is often needed to determine if the employee has a disability covered by the ADA and is entitled to an accommodation (i.e., has a permanent disability, as distinguished from temporary disability, that substantially limits one or more major life activities, affects the employee's ability to perform essential job functions, and is of sufficient severity) and if so, to help identify an effective accommodation.

Generally, in the context of an accommodation, medical inquiries related to an employee's disability and functional limitations are permissible and may include consultations with knowledgeable professional sources, such as doctors, occupational and physical therapists, rehabilitation specialists, and organizations with expertise in adaptations for specific disabilities. The employee should submit this form to their medical professional to obtain the needed medical documentation. The employee has the responsibility to ensure that the medical professional follows through on requests for medical information.

TO BE COMPLETED BY THE EMPLOYEE

Harrison School District Two Limited Release of Medical Center Information

I give Harrison School District Two permission to explore eligibility, coverage and reasonable accommodations under the Americans with Disabilities Act of 1990, as amended (ADA). I understand that all information obtained during this process will be maintained confidentially and used in accordance with ADA and all legal and regulatory requirements governing medical information. In situations where the District requires input on questions related to medical or psychological documentation submitted to support a request for reasonable accommodation, I authorize the District to consult with my medical/mental health professional that provided documentation.

Employee's Printed Name: _____ School/Dept: _____

Employee's Signature: _____ Date: _____

Medical Professional's Name: _____

Address: _____

Phone Number: _____

Employee's Name: _____

Employment Position Held: _____ *(see attached job description)*

Employee's Phone Number: _____

Please contact the employee's supervisor with any questions or concerns about the employee's job duties:

Supervisor's Name: _____ Phone Number: _____

Dear Medical Professional,

Harrison School District Two and _____ (Employee's Name) are requesting that you examine the employee to provide information regarding two general issues: (a) whether the employee has a physical or mental impairment that substantially limits one or more major life activities, including any functional limitations associated with such impairment(s), and (b) whether the employee's medical condition precludes work performance and suggested accommodations that would enable the employee to perform all the essential functions of his/her position.

TO BE COMPLETED BY THE MEDICAL PROFESSIONAL

Employee Name: _____ Date: _____

Please respond fully to the questions that follow. Attach additional documentation if necessary.

- Does the employee have an impairment? Impairment meaning any physiological disorder or condition affecting one or more of the body's systems, including mental conditions.

YES NO

- If yes, does the impairment affect a major life activity? Major life activities include functions such as walking, speaking, hearing, breathing, seeing, sleeping, learning, caring for oneself, sitting, standing, lifting, communicating, interacting with others, and working.

YES NO

- If yes, please indicate the nature of the physical or mental impairment(s) and the major life activity it limits:

- If yes, is the employee's ability to perform the major life activity substantially and materially limited by the impairment compared to how an average person in the general population performs the activity? Substantial limitation means that the employee is significantly restricted as to the condition, manner, or duration under which he/she performs the activity.

YES NO

- Is this condition permanent or temporary? Please explain.

TO BE COMPLETED BY THE MEDICAL PROFESSIONAL

- If temporary, when would the impairment reasonably be expected to no longer limit a major life activity?

• Is there a medical reason why the employee cannot perform any functions of the job as described to you?

YES NO

• If yes, what function(s) cannot be performed?

• What is the medical reason for the employee's inability to perform the above identified job functions? Please include any medical diagnosis that will assist us in understanding the need for the accommodation(s).

• Can you identify a reasonable accommodation that may enable the employee to perform the functions of the job.

YES NO

TO BE COMPLETED BY THE MEDICAL PROFESSIONAL

• If yes, provide specific recommendations of accommodations that may enable the employee to perform the affected job function(s), or that may overcome an identified barrier in the workplace associated with the impairment.

• Will the employee be able to perform the essential functions of their job if they receive this accommodation? Please explain.

• Please provide any other information and suggestions you might have on how this accommodation can be provided.

• Is there a medical reason to believe that the employee is likely to experience injury, harm, or aggravation of an impairment by performing or attempting to perform his/her job duties?

YES NO

TO BE COMPLETED BY THE MEDICAL PROFESSIONAL

• If yes, what is the degree of injury, harm, or aggravation that should be expected, and what is the likelihood that it will occur? Please also address the duration of the risk and the medical basis for your conclusions.

Thank you for your professional attention to this matter. Please assist us further by signing below to indicate that you have personally evaluated this employee and reviewed the medical information and attached job description.

Medical Professional's Signature: _____ Date: _____

Print Name and Title: _____