

DATE RECEIVED BY HR: _____

**WALLER INDEPENDENT SCHOOL DISTRICT
EMPLOYEE REQUEST FOR ACCOMMODATION**

NAME _____

SCHOOL or DEPARTMENT _____

POSITION _____

EMPLOYEE ID _____

Identify your impairment(s) and indicate how you believe the impairment(s) affects your ability to perform your job duties:

State the accommodation(s) you believe are necessary to enable you to perform the essential functions of your job:

Provide the following information on the health care provider who will support your need for an accommodation, if requested. We may contact the health care provider to obtain information about your impairment and recommendations for accommodations. Please attach a copy of the Medical Release to this form.

Name _____

Address _____

Phone _____

Fax Number _____

Signature of Requestor

Date of Request

RETURN THIS REQUEST TO:
Stephanie Fletcher, Director of Human Resources & ADA Administrator
20600 Fields Store Road
Waller, Texas 77484
(936) 931-3685