STAFFORD MUNICIPAL SCHOOL DISTRICT

ADA ACCOMMODATION REQUEST FORM

Human Resources | Employee Accommodation Request

TO BE COMPLETED BY EMPLOYEE

Employee Name (First, MI, Last):

Employee ID #:

Job Title:

Work Location:

Home/Cell Phone #:

Personal Email Address:

Work Email:

Work Location/Campus:

Supervisor Name:

Supervisor Email:

Please describe the nature and severity of your disability.

Describe the functional limitations caused by your disability for which you are requesting an accommodation.

Describe the specific accommodation(s) you are requesting.

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SUPPORTING DOCUMENTATION REQUIRED

Please have your licensed medical professional submit a signed statement on clinic/hospital letterhead that includes the following:

1. **Medical diagnosis/disability (including severity and nature)**
2. **How your disability impacts your ability to perform the essential functions of your job?**
   - What activities are impacted or limited?
3. **Recommended accommodations:**
   - If requesting intermittent time off, the physician must include the anticipated frequency and duration of absences needed for appointments and/or flare-ups.
   - If requesting continuous time off, your physician must provide the estimated start and end dates for the period of time needed to address your medical condition.
4. **Duration of the need for accommodation**

Duration of accommodation: _____

Employee Signature and Date

_____

Employee Signature Date

Submit completed form and supporting documentation to:

Stafford Municipal School District
Human Resources Department
1633 Staffordshire Rd., Stafford, TX 77477
Ph: 281-261-9200
Email: humanresources@staffordmsd.org