Quitman School District
ADA Reasonable Accommodation Request Form

Employee Full Name: _____ Date of Request: _____

Job Title: _____ Work Location: _____

Phone Number: _____ Email Address: _____

Procedure

It is the policy (GAAA) of the Quitman School District to consider all requests for reasonable accommodation on an individualized and interactive basis. Employees should submit the ADA Reasonable Accommodation Request Form to his or her supervisor. All reasonable accommodation requests made to a supervisor should be reported to the Superintendent's Office immediately. Once a request has been made, the Superintendent's Office will begin the interactive process. A meeting will be scheduled with the employee and employee's supervisor to discuss possible reasonable accommodations. Under the ADAAA, an extension of non-paid medical leave may constitute a reasonable accommodation.

Nature of Condition: _____
_____
_____
_____

Essential Function(s) Employee is Unable to Perform or is Limited in Performing:
_____
_____
_____
_____

Accommodation Requested: _____
_____
_____
_____

Estimated Cost of Accommodation to District:
_____
_____
_____

Alternative Accommodation(s): _____
_____
_____
_____

Local, State, Federal Agencies Available to Assist With Accommodation:

_____

_____

I understand that Quitman School District will review this request and a determination will be made as to whether the district can reasonably accommodate this request without imposing an undue hardship. I also understand that I may be required to present medical documentation regarding the condition and limitations described above. I certify that the information I provided on this form is true and correct. I also understand that if I have falsified any information on this form, disciplinary measures may occur.

_____ _____

Employee Signature Date

FOR OFFICE USE

Date completed paperwork received by Supervisor: _____

Date Received in Superintendent's Office: _____

Date of meeting with employee and Supervisor: _____

Accommodation Requested Approved and Date Employee Notified: _____

Alternative Accommodation Approved and Date Employee Notified: _____

Accommodation Denied and Date Employee Notified: _____

Date received in Payroll: _____

Certification of Physician or Practitioner
For ADA Purposes

Section I: To be completed by Employee

Employee Full Name: _____ Date: _____

I hereby authorize the release of the following information to Quitman School District for the purpose of determining the feasibility of reasonable workplace accommodations. I further authorize Quitman School District to seek clarification of this documentation, if necessary, by contacting my physician or health care provider.

Employee Signature: _____

Section II: To be completed by the physician or health care provider

Attached to this form is the current description of the essential functions of the position occupied by the above employee, including the physical and mental demands of the job. Please answer the following questions regarding the employee's condition as it relates to the essential functions and possible accommodations.

Under the ADA, a person with a disability is defined as follows:

- An individual with a physical or mental impairment that substantially limits one or more major life activities.
- An individual with a record of a substantially limiting impairment.
- An individual who is perceived to have such an impairment.

1. Is this employee currently suffering from a physical or mental condition which affects his/her abilities to perform daily life activities?
   _____ Yes _____ No (stop here, sign and date)

2. If your answer to question (1) was "Yes", please describe what these effects are. (Please attach additional sheets if necessary.) _____
   _____
   _____
   _____

3. If your answer to question (1) was "Yes", are these effects expected to substantially resolve or end within the next 12 to 18 months.
   _____ Yes _____ No

4. Does the employee use any mitigating measures (medications, assistive technologies, etc.)?
   _____ Yes _____ No

5. If your answer to question (4) was "Yes", How does the mitigating measures affect the disability?

_____

_____

6. Can the employee perform the essential job duties listed on the attached job description without risk of injury or other harm to his/herself or others?
   _____ Yes _____ No

7. If your answer to question (6) was "No", please describe specifically which functions listed on the attached job description this employee cannot perform without risk of injury or other harm to him/herself or others. _____
   _____
   _____
   _____

8. Can the employee perform the essential job duties listed on the attached job description without risk of injury or other harm to his/herself or others **with some type of accommodation**?
   _____ Yes _____ No _____ N/A

9. If your answer to question (8) was "Yes", in your opinion what accommodation would allow the employee to perform the essential job duties listed on the attached job description?
   Telework Frequent Breaks Modified workday Extension of non-paid medical leave
   Other _____
   _____

10. Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?
    _____
    _____

11. If the employee cannot perform the essential job duties listed on the attached job description with or without an accommodation, what type of work, if any, can the employee perform with or without an accommodation and without risk of injury or other harm to his/herself or others? Please be specific.
    _____
    _____
    _____
    _____

_____ _____

Health Care Provider Printed Name Specialization

_____ _____

Signature Date