

## REASONABLE ACCOMMODATION REQUEST PHYSICIAN FORM

Dear Physician:

A request for a reasonable accommodation has been made by our employee,\_\_\_\_\_. To determine whether or not this request should be granted and how best to respond to this request, the Jamestown Public School District is requesting that you complete the following form.

### ADA Qualifying Disability

An employee has a disability if s/he has an impairment that substantially limits one or more major life activities or a record of such impairment.

- Does the employee have a physical or mental impairment? (Includes any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.)  
 Yes    No

If yes, specify the impairment:

- Does the impairment substantially limit one or more major life activities or bodily functions?  
 Yes    No

Check all that apply:

- 
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Caring for oneself  | <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> Hearing   |
| <input type="checkbox"/> Seeing <sup>1</sup> | <input type="checkbox"/> Eating                  | <input type="checkbox"/> Sleeping  |
| <input type="checkbox"/> Walking             | <input type="checkbox"/> Standing                | <input type="checkbox"/> Lifting   |
| <input type="checkbox"/> Bending             | <input type="checkbox"/> Speaking                | <input type="checkbox"/> Breathing   |
| <input type="checkbox"/> Learning            | <input type="checkbox"/> Reading                 | <input type="checkbox"/> Concentrating                                     |
| <input type="checkbox"/> Communicating       | <input type="checkbox"/> Working                 | <input type="checkbox"/> Operation of a major bodily function <sup>2</sup> |

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Thinking      Other: \_\_\_\_\_

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Describe how the major life activity or operation of major bodily function is affected (do not take into account mitigating measures such as medication):

<sup>1</sup> Do not check if this can be corrected through eye glasses or contact lenses

<sup>2</sup> Includes, but is not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions

**Determination of Reasonable Accommodation** *(Answer only if the employee has a disability meeting the definition above)*

1. Please review the attached job description. Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?

Yes  No

If yes, please continue to next question. If no, please list which job functions s/he is unable to perform and how long the employee will be unable to perform these job duties.

Functions unable to perform:

\_\_\_\_ # of weeks    \_\_\_\_ # of months    \_\_\_\_ permanently

2. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

3. The employee's typical schedule is \_\_\_\_\_  
( list days and hours). What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential job functions?

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

5. How long will the employee need the reasonable accommodation? If unable to provide a date, when will he or she be medically reevaluated?

Any additional comments or suggestions:

\_\_\_\_\_  
Physician Name (Please Print)

\_\_\_\_\_  
Signature of physician completing form

\_\_\_\_\_  
Date