Washtenaw I S D
A REGIONAL EDUCATIONAL SERVICE AGENCY

REQUEST FOR REASONABLE ACCOMMODATION (MEDICAL)

SECTION I – FOR COMPLETION BY EMPLOYEE.

Please complete Section I of this form. Then provide this form, together with a copy of your job description, to your medical professional to complete Section II. Either you or your medical provider may return the completed form to Human Resources; the District's American's with Disability Act (ADA) Coordinator, or designee, shall process. Information submitted shall be treated as confidential to the extent permitted by law. Please note that your request for an accommodation cannot be initiated until Section I and Section II of this form are completed.

A. EMPLOYEE INFORMATION

Name: _____

First Middle (optional) Last

Position/Classification: _____

Department /Program: _____

Supervisor: _____

B. **DISABILITY (ADA)**

Select the one that is appropriate. Attach a copy of supporting medical documentation.

_____ Mental

_____ Physical

_____ Both

C. **ACCOMMODATION(S)**

1. I attest that I have requested and reviewed my position description. (Attach copy of current job description). ____ Yes _____ No

2. Describe your current job duties that require an accommodation because of a disability.

_____

_____

_____

_____

_____

3. Describe the functional limitations caused by your disability for which you are requesting an accommodation. Submit additional page(s), if necessary.

_____

_____

_____

4. State the accommodation(s) that you believe would minimize and/or eliminate the functional limitations listed above.

_____

_____

_____

_____

_____

I certify that the information contained on this form and submitted with this form is true and correct.

Employee Signature: _____ Date: _____

SECTION II – FOR COMPLETION BY MEDICAL PROVIDER.

Please answer all parts based on your medical knowledge, experience, and examination of the employee - patient. The employee MUST provide you with a copy of their job description. The following sections of the job description should be referenced when completing this form: duties/responsibilities, essential functions, and physical requirements. Please attach additional sheets if more space is needed. **When completed, please sign and return the form to the patient (or forward to the Human Resources Confidential Fax at 734/994-1629).**

1. Health Care Provider's Name, Address and Telephone Number

_____

_____

2. Does this employee - patient have a physical or mental impairment? ____Yes or ____ No.

IF YES, state the type of impairment. _____

_____

3. List each major life activity limited by the impairment (identified in #2) and describe how the patient is restricted due to the disability.

_____

_____

_____

_____

4. What is the duration (or expected duration) of the patient's impairment?

_____

_____

5. Can the patient perform all duties listed in the job description provided? ____Yes or ____ No

IF NO, state which job functions cannot be performed and why.

_____

_____

_____

_____

6. Describe any reasonable accommodation and/or accommodations that would allow the patient to perform the job functions listed above. If medical leave is one of the possible accommodations, please provide an estimated duration for the leave.

_____

_____

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_____

7. Would performing any job function listed in the job description result in a direct safety or health threat to the patient or other people (coworkers, the public, etc.). ____Yes or ____ No

IF YES, state which job functions would pose a threat, what that threat could be, and any reasonable accommodation that would eliminate/reduce the threat to an acceptable level.

_____

_____

_____

_____

Medical Provider's Signature: _____ Date:_____