The purpose of this form is to assist the Clarence Central School District in determining whether or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. *This form must be filed separately from the employee's personnel file and be treated confidentially.*

<u>This form is to be completed by the employee requesting the accommodation and must be submitted by the employee to the Personnel Department:</u>

Employee Name:	
Building/Department:	Telephone:
Job Title:	Date:
Principal/Supervisor:	

I give the Clarence Central School District permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act of 1990, as amended (ADA). I understand that all information obtained during this process will be maintained and used in accordance with ADA and all legal and regulatory requirements as they pertain to medical and genetic information confidentiality. In situations where the District requires input on questions related to medical or psychological documentation submitted to support a request for reasonable accommodation, I authorize the Personnel Director or District Medical Directors to consult with the medical/mental health professional that provided documentation.

Employee's Signature:_____ Date: _____

Reasonable Accommodation Request Form

Please answer the following questions to assist us in understanding the basis and nature of your request for a reasonable accommodation (attach additional sheets if necessary).

A. Specify the physical or mental limitation(s) interfering with your ability to perform your job or access an employment benefit, and the expected duration of the limitation(s). It is not necessary to indicate a medical diagnosis or condition.

_____
_____
_____
_____

B. Explain how the disability/limitation affects your ability to perform one or more functions of the job or access an employment benefit:

_____
_____
_____
_____

C. List the accommodation(s) you believe are needed to enable you to perform essential job functions or access a benefit of employment and specify how the requested accommodation(s) will assist you. If equipment is requested be specific.

_____
_____
_____
_____

D. Has a physician, vocational rehabilitation specialist, or other health professional recommended a specific accommodation?

Yes ☐ No ☐

If yes, please attach a copy of their recommendations.

INFORMATION PERTAINING TO MEDICAL DOCUMENTATION:

After reviewing the initial request and any supporting medical documentation submitted by the employee, additional medical documentation and/or an

examination may be necessary to determine your need for a reasonable accommodation and possible options. In such cases, a request for additional information and/or a medical appointment notice will be provided to the employee.

In the context of assessing an accommodation request, medical documentation is often needed to determine if the employee has a disability covered by the ADA and is entitled to an accommodation.

Generally, in the context of an accommodation request, medical inquiries related to an employee's disability and functional limitations are permissible and may include consultations with knowledgeable professional sources, such as doctors, occupational and physical therapists, rehabilitation specialists, and organizations with expertise in adaptations for specific disabilities. The Personnel Department is charged with collecting medical documentation. In the event that medical documentation is required, the *employee will be notified* to submit documentation from their medical provider. The Superintendent of Schools is authorized to direct the employee for a fitness-for-duty evaluation by the District's physician.

GRANTING AN ACCOMMODATION

After the review of the employee's request, medical documentation, and any medical consultation, if it is determined that an employee has a disability that requires an accommodation, the Personnel Department will coordinate a meeting with the employee and employee's supervisor in order to discuss accommodation options. If a reasonable accommodation is possible and granted, it may be reevaluated, modified or terminated due to changes in circumstances.

HIPAA Compliant Authorization for Disclosure of Health Information for Use in Request for Reasonable Accommodations

(For Direct Communication with Health Care Provider)

Name of Employee: _____ **Date of Birth:** _____

Address of Employee: _____