EASTPOINTE
COMMUNITY SCHOOLS

Americans with Disabilities Act
ACCOMMODATION REQUEST ASSESSMENT FORM

Date: _____

Regarding: Employee Name: _____

Employee DOB: _____

Authorization for Release of Information

I, _____, hereby authorize both my physician, _____, and my employer, Eastpointe Community Schools to share written/verbal information regarding my residual functional capacity, any limitations or restrictions on my ability to perform the functions of my position and any devices, equipment, or accommodations I require to enable me to perform these functions.

_____ _____

Employee Signature **Date**

COMPLETED FORM MUST BE RETURNED TO EMPLOYER WITHIN 10 DAYS OF THE DATE OF THIS PACKET

The above employee has requested a workplace accommodation, to enable the employee to perform the essential functions of his/her position, either because of a disability as either defined under the Americans with Disabilities Act (ADA), as amended, or state law, or because the employee is pregnant and seeks an accommodation under the applicable state pregnancy accommodation law. The information requested on this form will assist us in making a determination regarding the employee's request.

INSTRUCTIONS: *The following form must be completed in detail and signed by the employee's attending medical provider. Please attach additional pages or records as needed.* ***Do not provide information not related to the employee's ability to perform his/her job duties. Example: Do not identify an impairment if it does not have an impact on employee's ability to perform his/her job duties.***

IMPORTANT NOTICE REGARDING GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requirement genetic information of employees or their family members. Do not provide any genetic information when responding to this request for medical information.

Yes ☐ No ☐

1. Please confirm you have examined the employee and are familiar with the employee's medical history.
2. Is the employee released to return to work full time, full duty without the need for restrictions, limitations or accommodations?

   Yes ☐ No ☐

   If yes, please state the employee's full, unrestricted return to work date: _____

   IF NO, PLEASE COMPLETE THE REMAINDER OF THIS FORM.

3. When can the employee return to work with restricts or an accommodation? _____
   (Additional questions regarding restrictions or accommodations below)

4. *Existence of impairment.*

   a. Does the employee have a physical or mental impairment(s)?

      Yes ☐ No ☐

   b. Is the impairment open and obvious?

      Yes ☐ No ☐

If the employee's impairment is open and obvious, do not answer questions 5 – 8; rather skip to question 9 and proceed from there.

5. Please list impairment(s) do not provide medical diagnosis without patient consent:

_____

_____

_____

NOTE: A physical or mental impairment under the ADA is:

- Any physiological disorder, 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, genitourinary, hemi and lymphatic, skin, and endocrine; or

- Any mental or psychological disorder, such as an intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

- The disorder or condition is considered:

  - In its active state, even if presently in remission. (Examples: epilepsy, MS, asthma, cancer, bipolar disorder.)
  - Without regard to the effects of mitigating measures such as prostheses, medication, etc., except ordinary eyeglasses.
  - With consideration of the negative effects of treatment such as medication or other measures.

    *The definition of a disability may differ slightly under state law.

6. Limitations on major life activities. **If the answer to #4 is yes, does the employee's impairment substantially limit one or more major life activities?**

   Yes ☐ No ☐

Note: Whether an impairment substantially limits the ability of an individual to perform a major life activity is determined:

- As compared to most people in the general population; and
- Does not need to prevent or significantly or severely restrict, the individual from performing a major life activity – the impairment only needs to "substantially limit" the employee's ability to perform the major life activity.

7. Please describe impairments that would impact employee's ability to perform.

8. *Performance of essential job functions*. Does the employee's impairment(s) limit his/her ability to perform the essential functions of the employee's position (as defined in the job description) without any accommodation?

   Yes ☐ No ☐

   If the answer is yes, please:

   a. Identify which essential function(s) the employee is unable to perform without an accommodation:

   b. Describe the manner in which the employee's ability to perform each essential function is limited:

9. *Accommodation(s):* **Please describe:**

Note: Reasonable accommodations may include such things as a modified work schedule, provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee's position, and time for recovery, therapy, training, or other disability-related needs.

   a. Is employee specifically requesting a leave of absence as an accommodation?

      Yes ☐ No ☐

   b. Will a leave of absence assist the employee to return to work?

      Yes ☐ No ☐

   c. How will leave assist the employee in returning to work?

   d. *Duration*. What are the dates during which you anticipate the employee will need the leave of absence?

NOTE: You must provide your best medical judgment, based on current information, as to the length of time the employee will need an accommodation to perform his/her essential job functions.

10. Is there other accommodation(s) instead of a leave of absence that will enable the employee to perform the essential job functions? If so, please describe:

_____

a. How will the accommodation(s) assist the employee in performing the essential job functions?

_____

_____

_____

b. Duration. How long do you anticipate the employee will need the identified accommodation(s) to perform the essential job functions?

_____

NOTE: You must provide your best medical judgment, based on current information, as to the length of time the employee will need an accommodation to perform his/her essential job functions.

11. Additional information. Are you aware of any other information that Roseville Community Schools should consider in assessing whether the employee can perform the essential job functions with or without accommodation?

Yes ☐ No ☐

If yes, please describe:

_____

_____

_____

_____

_____

Provider Name (print): _____

Provider Signature: _____

Provider Practice/Specialty: _____

Provider Phone Number: _____

Provider Address: _____

Date: _____