Clayton County Public Schools – Equity and Compliance Division

Request for Reasonable Accommodation Packet (Employee/Physician Packet)

# Instructions for Employee

**Step 1:** Complete the “Employee Accommodation Request” form and the “Employee Authorization for Release of Medical Information” form. Sign and date where indicated.

**Step 2:** Take the “Employee ADA Medical Certification” form, along with a copy of your job description supplied by the Benefits Department and the “Employee Authorization for Release of Medical Information” form, to the appropriate physician. Request that your physician examine the job description and complete the “Employee ADA Medical Certification” form.

**Step 3:** You, or your physician, should return the completed forms (1. The “Employee Accommodation Request” form; 2. The “Employee Authorization for Release of Medical Information” form and the “Employee ADA Medical Certification” form) to the CCPS Equity and Compliance Division (by personal delivery, mail, or fax).

Clayton County Public Schools

CCPS Equity and Compliance Division

1058 Fifth Avenue

Jonesboro, GA 30236

Phone: 770.473.2700

Fax: 678.817.3084

**Step 4:** Wait for CCPS’s Equity and Compliance Division to contact you for an appointment to begin the interactive process of evaluating your request.

**NOTES TO EMPLOYEE:**

* Clayton County Public Schools will make every effort to reasonably accommodate employees in accordance with the Americans with Disabilities Act of 1990 (ADA), as amended.
* The ADA defines disability as a mental or physical impairment that substantially limits a major life activity, and generally requires accommodation for employees who are qualified to perform their essential job duties and have a disability or have a record of having a disability.

# Instructions for Physician

* Review the duties and requirements on the employee’s job description
* Fully complete the “Employee ADA Medical Certification” and return it to the employee or directly to CCPS’s Equity and Compliance Division.

Clayton County Public Schools

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**EMPLOYEE ACCOMMODATION REQUEST FORM**

**TO BE COMPLETED BY THE EMPLOYEE**

|  |
| --- |
| Reasonable accommodations may be needed to provide equal access and opportunities to qualified individuals with disabilities. If you are an employee with special needs that are the result of a disability and you believe that reasonable accommodations will assist you in the performance of your job, please complete this form and return it to the district’s Equity and Compliance Division. |
| EMPLOYEE NAME |  | Employee ID |  | HOME PHONE |
| JOB TITLE |  | WORK LOCATION(building) |  |  |
| DEPT |  | WORK PHONE |  |  |
| SUPERVISOR |  | SUPERVISOR PHONE |  |  |
| WORK SCHEDULE (DAYS AND HOURS) |  |  |
| **Please use back of sheet if you need more room to answer any questions listed below.** |
| 1. Please describe the physical, mental, or cognitive impairment(s) that limit your ability to do your job. |
| 2. Describe the accommodations you are requesting. Be as specific as possible (i.e. If you are requesting a piece of equipment or a device, please provide description, manufacturer, cost, where to order, etc.) |
| 3. Describe how the requested accommodations will enable you to perform your job. |
| 4. Please provide any other information that might help evaluate your request. |
| I give Clayton County Public Schools permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate district personnel and/or my health care professional. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job. |

Signature Date

Clayton County Public Schools

**EMPLOYEE AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM**

**TO BE COMPLETED BY THE EMPLOYEE**

TO:

Name of Medical Provider

Address

City State Zip Code

RE:

Name of Patient, Birth date or SSN

Address

City State Zip Code

I hereby authorize

Medical Provider

to disclose to Clayton County Public Schools, or any other person, including the agency’s legal counsel, who is authorized by my employer to handle medical information for ADA purposes any information concerning my physical or mental condition, that are necessary to determine whether I have a disability and to determine whether any accommodations can be made.

I also authorize Clayton County Public Schools’ Equity and Compliance Division representative, or any other person who is authorized by my employer to handle medical information for ADA purposes, to speak to my treating physician or health care provider directly in regards to any questions they may have with respect to my condition that relates to the performance of the essential functions of my job and any accommodations that may be necessary.

I understand that the requested data is for the above-mentioned purposes, and that I may refuse to provide the requested medical information. However, I understand that if I refuse to provide the information, my employer may refuse to provide reasonable accommodation.

This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Signature of Patient Date



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**EMPLOYEE ADA MEDICAL CERTIFICATION**

**NOTE: the information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| To be completed by **EMPLOYEE** | **Employee Name** |  | **D.O.B.** |  | **Employee ID** |  |
| **Job Title:** |  | **Department:** |  |
| **I authorize my medical provider(s) to release the following information from my patient file to Clayton County Public Schools for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).** |
| **Employee Signature:** | **Date:** |
| To Be Completed by the**HEALTHCARE PROVIDER** | **INSTRUCTIONS:** Attached are copies of the employee’s job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review both the attached job description and job analysis and then complete and sign this form.** |
| **Physician Name:** |  | **Specialization / Type of Practice:** |  |
| **Address:** |  | **Fax No:** |  | **Phone No.:** |  |
| **Questions to help determine whether an employee has a qualifying disability.** A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities. |
| **1**. Does the employee have a physical or mental impairment? |  |  |  |  |  |  |  Yes |  | No |
| **2.** What is the impairment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |
| **3.** Is the impairment permanent? |  |  |  |  |  |  |  | Yes |  | No |
| **4.** If not permanent, how long will the impairment likely last? |  |  |  |  |  |  |  |  |  |
| 1. Is this a condition which:
	1. Requires periodic visits for treatment by a health care provider?
 |  |  |  |  |  Yes |  | No |
| **B. Co**ntinues over an extended period of time? |  |  |  |  |  |  |  | Yes |  | No |
| **C. M**ay cause episodic rather than a continuing period of incapacity? |  |  |  | Yes |  | No |
| **6.** Is the patient taking medications or treatments that would be expected to affect job performance, that would pose a direct threat or safety risk?(See attached job description for statement of duties) | Yes |  | No |
| If yes, please explain |  |  |  |  |  |  |  |  |  |  |
| **7.** Does the impairment affect a major life activity? |  |  |  |  |  |  |  | Yes |  | No |

|  |  |
| --- | --- |
|  | I certify that the employee has a physical, mental, emotional, impairment that limits one or more major life activity. Below, please indicate the life function affected and the limitations of the employee. |
| **Physical Activity** | **Mild Limitation** | **Moderate Limitation** | **Severe Limitation** |
| Sitting |  |  |  |
| Standing |  |  |  |
| Walking |  |  |  |
| Bending Over |  |  |  |
| Climbing |  |  |  |
| Reaching Overhead |  |  |  |
| Kneeling |  |  |  |
| Pushing & Pulling |  |  |  |
| Crouching/stooping |  |  |  |
| Lifting or Carrying |  |  |  |
| * 10 lbs or less
 |  |  |  |
| * 11 to 25 lbs
 |  |  |  |
| * 26 to 50 lbs
 |  |  |  |
| * 51 to 75 lbs
 |  |  |  |
| * 76 to 100 lbs
 |  |  |  |
| * Over 100 lbs
 |  |  |  |
| Repetitive Use of Hands |  |  |  |
| * Right Only
 |  |  |  |
| * Left Only
 |  |  |  |
| * Both
 |  |  |  |
| Simple/Light Grasping |  |  |  |
| * Right Only
 |  |  |  |
| * Left Only
 |  |  |  |
| * Both
 |  |  |  |
| Firm/Strong Grasping |  |  |  |
| * Right Only
 |  |  |  |
| * Left Only
 |  |  |  |
| * Both
 |  |  |  |
| Fine motor, right hand |  |  |  |
| Fine motor, left hand |  |  |  |

|  |  |
| --- | --- |
|  | **Indicate Level of Mental, Emotional, and Sensory Limitations** |
| Pace of Work | Fast Avg Below Avg | Reasoning | Mild Moderate Severe |
| Manage Multiple Priorities | Mild Moderate Severe | Hearing | Mild Moderate Severe |
| Intense Customer Interaction | Mild Moderate Severe | Reading | Mild Moderate Severe |
| Multiple Stimuli | Mild Moderate Severe | Analyzing | Mild Moderate Severe |
| Frequent Change | Mild Moderate Severe | Verbal Communication | Mild Moderate Severe |
| Short-term Memory | Mild Moderate Severe | Written Communication | Mild Moderate Severe |
| Long-term Memory | Mild Moderate Severe | Vision | Mild Moderate Severe |
| Attention Span | Mild Moderate Severe |  |  |
| To Be Completed by the**HEALTHCARE PROVIDER** | **Questions to help determine whether an accommodation is needed.****1.** What limitation(s) in major life activities is/are interfering with this employee's job performance? |
| **2.** What essential job function(s) listed in the job analysis is the employee having trouble performing because of the limitation(s)? |
| **3.** How does the employee’s limitation(s) in major life activities interfere with his/her ability to perform the essential job functions listed in the attached job analysis? |
| **Questions to help determine effective accommodation options.****1.** Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they? |

|  |  |
| --- | --- |
|  | **2.** How would your suggestion(s) improve the employee’s ability to perform the essential function of his/her duties? |
| **Comments:** |
| **PHYSICIAN NAME and COMPANY/BUSINESS NAME:** |
| **SIGNATURE of HEALTHCARE PROVIDER:***Stamps and Designee Signatures* ***NOT*** *Accepted In Lieu of Physician’s Signature*  | **Date:** |

**ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL NOT BE RETAINED IN THE EMPLOYEE’S PERSONNEL FILE.**