Rochester School Department

Accommodation Request Assessment Form

Date: _____ Employee full name: _____ Employee DOB: _____

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. 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. In addition, please do not provide any genetic information when responding to the request.

1. Please confirm you have examined the employee and are familiar with the employee's medical history. _____ Yes _____ No

2. Is the employee released to return to work full time, full duty without the need for restrictions, limitations, or accommodations?

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

_____No, Please complete the remainder of this form.

3. Date the employee can return to work with restrictions or an accommodation? _____

[Additional questions regarding restrictions or accommodations below.]

4. Does the employee have a physical or mental impairment? _____ Yes _____ No

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

6. If the answer to questions #4 is yes, does the employee's impairment substantially limit one or more major life activities in comparison to most people in the general population? _____ Yes _____ No

7. If the answer to question #6 is yes, which major life activity(s) is/are affected? *Check all major life activities that both (a) are substantially limited in comparison to most people in the general population* ***and*** *(b) restrict or limit the employee's ability to perform the employee's job duties.*

Major life activities – general life activities:

□ Bending □ Breathing □ Caring for self □ Concentrating □ Eating □ Hearing	□ Interacting with others □ Learning □ Lifting □ Performing manual tasks	□ Reaching □ Reading □ Seeing □ Sitting □ Sleeping □ Speaking	□ Standing □ Thinking □ Walking □ Working □ Other(s) (describe)

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Question 7 continued:

Major life activities – operation of major bodily functions:

□ Bladder	□ Digestive	□ Lymphatic	□ Reproductive
□ Bowels	□ Endocrine	□ Musculoskeletal	□ Respiratory
□ Brain	□ Genitourinary	□ Neurological	□ Sensory organs & skin
□ Cardiovascular	□ Hemic	□ Normal cell growth	□ Other(s) (describe)
□ Circulatory	□ Immune	□ Operation of an organ	

8. *Commencement of impairment(s).* For the impairments identified above, when did t h e employee's impairment(s) commence? If there is more than one impairment, please specify the start date for each:

9. *Performance of essential job functions.* Does the employee's impairment(s) substantially limit his/her ability to perform the essential functions of the employee's position without any accommodation?

_____ Yes _____ No

10. If the answer to question #9 is yes:

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:

11: Please describe the accommodation(s) requested:

a. For how long do you anticipate the employee will need the identified accommodation(s) to perform the essential job functions?

_____ (circle one) days/weeks/months/years ***OR*** _____ Permanent

Provider Name (print): _____

Provider Signature: _____

Provider Practice/Specialty: _____

Provider Address: _____

Provider Phone Contact: _____