HUMAN RESOURCES DIVISION
DEPARTMENT OF EDUCATION
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JUDITH T. WON PAT, ED,D.
ACTING SUPERINTENDENT OF EDUCATION

KATHERINE M.P. ADA
PERSONNEL SERVICES ADMINISTRATOR

ADA Reasonable Accommodation Request Form

CONFIDENTIAL – HR / MEDICAL RECORD

Section A: Employee Information

Employee Name: _____

Employee ID (EIN): _____

Position Title: _____

Worksite / School / Division: _____

Supervisor Name: _____

Work Phone / Email: _____

Section B: Nature of Request

1. Describe the medical limitation affecting your ability to perform essential job functions:_____

_____

_____

2. Date limitation began: _____

3. Condition: ☐ Temporary ☐ Permanent ☐ Unknown

Section C: Accommodation Requested

☐ Modified duties
☐ Modified schedule / reduced hours
☐ Light duty assignment
☐ Equipment / assistive devices
☐ Reassignment
☐ Temporary medical leave
☐ Other: _____
Details:

_____

_____

Section D: Medical Certification (To Be Completed by Health Care Provider)

Health Care Provider Name: _____

Clinic / Facility: _____

Phone: _____ Fax: _____

Can employee perform essential functions with accommodation?

☐ Yes ☐ No ☐ Undetermined

Recommended accommodation(s):

_____

_____

_____

Expected duration of limitations:

☐ Less than 30 days ☐ 30–90 days ☐ More than 90 days ☐ Permanent

Estimated End Date (if applicable): _____

Provider Signature: _____ Date: _____

Section E: Employee Acknowledgment

I certify that the information provided is true and complete. I authorize the release of relevant medical information to GDOE Human Resources solely for purposes of evaluating this accommodation request.

Employee Signature: _____ Date: _____

Section F: Supervisor Input

Essential Job Functions Impacted:

_____

_____

_____

Supervisor Recommendation:

☐ Support ☐ Do Not Support ☐ Neutral / Requires Review

Supervisor Signature: _____ Date: _____

Section G: HR / EEO Review and Determination (HR Use Only)

Date Received by HR: _____

Interactive Process Meeting Date(s): _____

Determination: ☐ Approved ☐ Approved with Modifications ☐ Denied ☐ Pending

Approved Accommodation(s):

_____

_____

Effective Date: _____

Review Date: _____

Case Manager: _____

HR/EEO Signature: _____ Date: _____

This form should be submitted to HR attention: Margaret Cruz.

Notice: Submission of this form initiates the ADA interactive process. All medical information will be maintained in a confidential file separate from personnel records.