ADA REASONABLE ACCOMMODATION REQUEST

To be eligible for a reasonable accommodation under the Americans with Disabilities Act (ADA), you must (1) be able to perform the essential functions of your position and (2) have a disability as defined in the ADA that substantially limits a major life function.

Employee Information

Name: ___________________________  Job Title: ___________________________

Department/Location: __________________  Daytime Phone Number: ___________________

Name of your Supervisor: __________________

1. Describe how your condition affects your ability to perform a major life activity. Which major life activity(ies) is/are most significantly affected? Examples of major life activities are: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function.

2. Describe any mitigating measures (medications, assistive technologies such as wheelchairs, etc.) you are using because of the disability, and the effect of those measures on the disability.

3. Describe how your condition limits your ability to perform the essential functions of your job. Identify the essential functions affected and be specific about how the medical condition impairs your ability in each instance.

4. Describe the accommodation you are requesting.

5. Explain how the accommodations you are requesting will enable you to perform the essential functions of your job. Be specific.
6. Will you be able to perform all of the essential functions of your job if you receive the requested accommodation(s)? If not, describe the specific function(s) you will not be able to perform.

7. Do you need assistance to identify accommodations that will enable you to perform the essential functions of your job? If you do, explain what type of assistance you need.

8. Provide any information or suggestions on how the requested accommodation(s) can be provided. If known, include the names, addresses and telephone numbers of vendors and the model number and approximate cost of any equipment requested.

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ADA Release of Information

I authorize my medical provider(s) to release information to, and if necessary, speak with the Newport News Public Schools Human Resources Office about my medical condition for the purpose of determining appropriate job accommodation(s) for my condition.

Physician Name: ___________________________  Physician Address:____________________________

Physician Fax number:_____________________

Employee Name: ___________________________  Signature:____________________________________
(Print)

Date: ________________________________

Please submit the completed form to:
(Fax)    757-597-2967
(Office) 12507 Warwick Boulevard
          Newport News, VA  23606