

## ADA Accommodation Request Forms and Completion Instructions

Please note that there are two ADA Accommodation forms that need to be completed and they are as follows:

- ADA Employee Accommodation Medical Certification Form

*This form is to be completed and signed by your healthcare provider*

- ADA Employee Accommodation Request Form

*This form is to be completed and signed by the employee*

Upon completion, please submit these forms via mail or email to:

ADA Coordinator

301 North Ninth Street, 15th Floor

Richmond, Virginia 23219

Email: [adarequest@rvaschools.net](mailto:adarequest@rvaschools.net)

**ADA Employee Accommodation Medical Certification**

**SECTION I: For Completion by the EMPLOYEE**

Your Name:

\_\_\_\_\_

First

\_\_\_\_\_

MI

\_\_\_\_\_

Last

Your Job Title: \_\_\_\_\_ Work Location: \_\_\_\_\_

Your Regular Work Schedule: \_\_\_\_\_

*Please attach a copy of your official Richmond Public Schools job description to this document prior to completion by your healthcare provider.*

**SECTION II: For Completion by the HEALTHCARE PROVIDER**

**Instructions to HEALTHCARE PROVIDER**

A request for a reasonable accommodation has been made by our employee, \_\_\_\_\_ . In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please answer the questions on this form to help determine disability and reasonable accommodation.

**BACKGROUND**

An employee has a disability if he/she has an impairment that substantially limits one or more major life activities or a record of such impairment. "Substantially limits" under the ADA Amendments Act (ADAAA) has been broadened to allow someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or expected duration less than or equal to six months.

The ADAAA provides examples of "major life activities," including "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, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

- PLEASE WRITE LEGIBLY
- DO NOT LEAVE ANY LINES BLANK
- 

Today's Date: \_\_\_\_\_

Healthcare Provider's Name (please print): \_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Business Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**SECTION II (cont.): For Completion by the HEALTHCARE PROVIDER**

**Please answer these questions to help determine disability and reasonable accommodation:**

1. Please review the attached job description. (If no job description is attached, please discuss the position with our employee to determine essential job duties.)

Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? Yes  No

➤ If yes, please continue to question #2.

If no, how long will the employee be unable to perform these job duties?

\_\_\_\_ # of weeks    \_\_\_\_ # of months    \_\_\_\_ permanently

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

➤ If yes, what is the impairment?

\_\_\_\_\_

3. What limitations are interfering with job performance, and how do they affect the employee's ability to perform the job functions? \_\_\_\_\_

\_\_\_\_\_

4. What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position? \_\_\_\_\_

\_\_\_\_\_

5. The employee's typical schedule is \_\_\_\_\_. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position? \_\_\_\_\_

\_\_\_\_\_

6. How would your suggestions improve the employee's job performance? \_\_\_\_\_

\_\_\_\_\_

7. How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?

\_\_\_\_\_

Any additional comments or suggestions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of physician completing form

**ADA Employee Accommodation Request Form**

**This form is to be completed by the Employee**

Your Name: \_\_\_\_\_  
First MI Last RPS Employee ID #

Your Job Title: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Location: \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_

Your Regular Work Schedule: \_\_\_\_\_

**INSTRUCTIONS:** Please print legibly or type on the document. Do not leave any spaces blank. Please use the back of the paper if you need additional room for responses to questions listed below.

1. Description of disability

2. How does the disability prevent you for performing the essential functions of your job duties and responsibilities?

3. I am requesting the following reasonable accommodation

**RICHMOND PUBLIC SCHOOLS**  
Attn: Talent Office – 15<sup>th</sup> Floor  
301 N. 9<sup>th</sup> Street – Richmond, VA 23219  
ADA Coordinator  
Email: [adarequest@rvaschools.net](mailto:adarequest@rvaschools.net)  
**ADA Employee Accommodation Request Form**

4. Describe how the requested accommodation(s) will enable you to perform your duties and responsibilities.

5. Any additional comments that you believe may assist this office in evaluating your request for accommodation(s).

► Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ADDITIONAL DOCUMENTATION WILL BE PROVIDED UPON COMPLETION OF THIS FORM.**

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301 North Ninth Street, 15th Floor  
Richmond, Virginia 23219  
Email: [adarequest@rvaschools.net](mailto:adarequest@rvaschools.net)

<b>For Official Office Use Only</b>	
Date Received: _____	Received by: _____
Comments: _____ _____	