EL PASO INDEPENDENT SCHOOL DISTRICT

Human Resources
Office of Employee Relations

Employee Accommodation Request Form

Request for Reasonable Accommodation

Instructions for SECTION I

The Employee Relations office in Human Resources is responsible for monitoring and addressing compliance with the Americans with Disabilities Act as well as Section 503 of the Rehabilitation Act of 1973. Please fully answer each item in Section I, then provide the form along with a copy of your job description, to your healthcare provider to complete Section II. For any questions regarding this form please contact Employee Relations at (915) 230-2018. Forward completed forms and attachments to Employee Relations, Human Resources, 6531 Boeing Drive, El Paso, Texas 79925 or to employeerelations@episd.org.

SECTION I: for Completion by Employee

Last Name: ______________________________ First Name: ____

Mailing Address: ____

City: ___________________________ State: ______________ Zip Code: __________________________

E-Mail: ____________________________ Home/Mobile Phone: _____________________________________

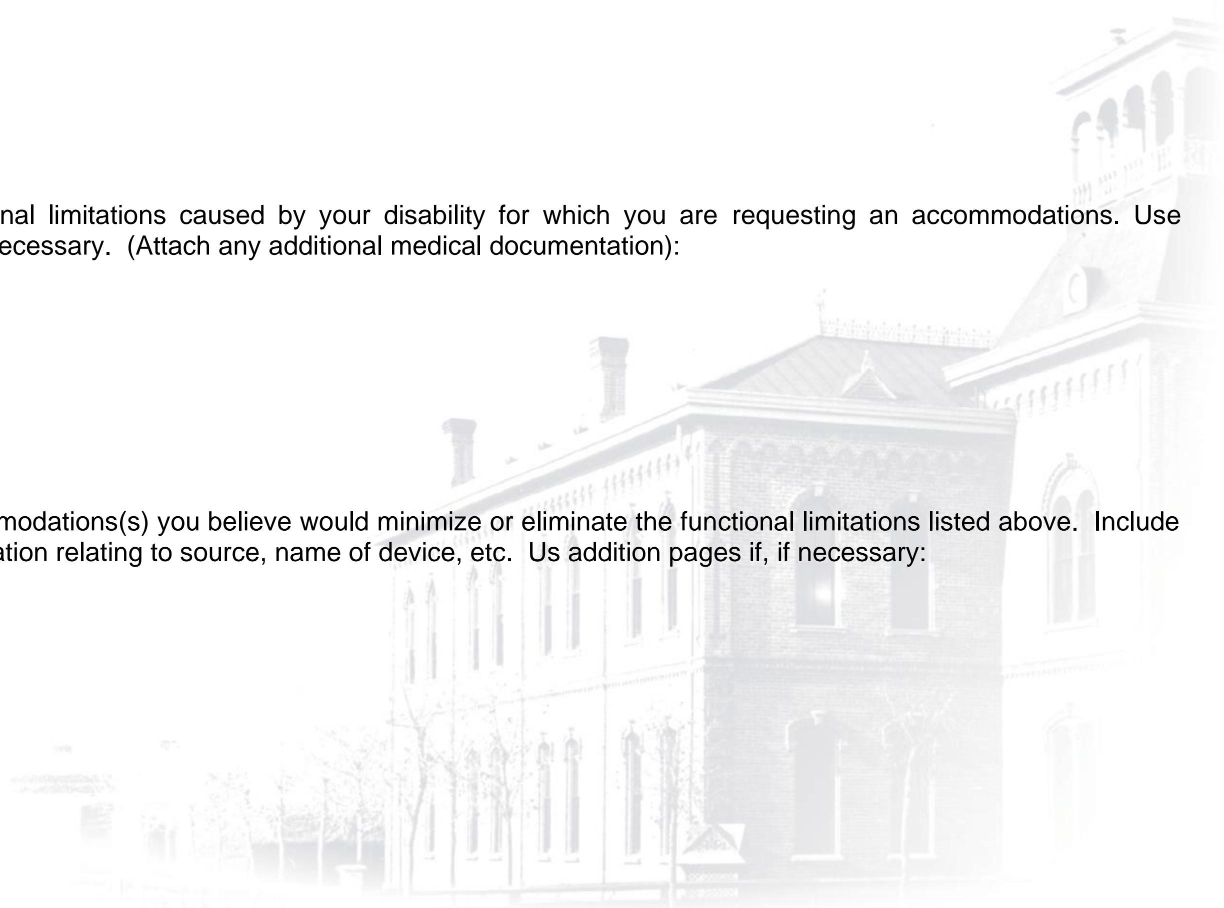
Work Phone: ______________________ Department: ____

Job Title: ________________________________ Employee ID # (found on back of badge): _____________________

Supervisor's Name: _____________________________ Supervisor's Phone Number: _____________________

Describe your current job duties requiring an accommodation because of a disability:

Describe the functional limitations caused by your disability for which you are requesting an accommodations. Use additional pages, if necessary. (Attach any additional medical documentation):



Describe any accommodations(s) you believe would minimize or eliminate the functional limitations listed above. Include any available information relating to source, name of device, etc. Us addition pages if, if necessary:

Authorization

I have voluntarily completed this Employee Accommodation Request Form and all information provided is true and accurate to the best of my knowledge or belief. I give the El Paso Independent School District (District) permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate District personnel and/or my healthcare professional, and acknowledge that such communication is job-related and consistent with business necessity. 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 may be required to provide appropriate documentation of my disability, including the impact of the functional limitation on my ability to perform the essential functions of my job.

Employee Name: ______________________________

Employee Signature: ______________________ Date: ______________________

Instructions for SECTION II

Once you have completed Section I, please submit Section II to your healthcare provider for completion, along with Section I and your job description. Upon completion of Section II by your healthcare provider, please submit both sections to the Employee Relations Department.

SECTION II: for Completion by Healthcare Provider

Please fully answer all applicable parts based on your medical knowledge, experience, and examination of the patient. The employee should provide you with a copy of their job description. Please refer to the following sections of the job description when completing this form: job duties, physical effort, and essential functions. Please attach additional pages if more space is needed.

Healthcare Provider's Name: ______________________________

Mailing Address: ______________________________

City: ____________________ State: __________ Zip Code: ____________

Phone Number: ____________________ Fax Number: ____________________

Employee (Patient) Name: ______________________________

Does this employee have a physical or mental impairment: YES NO

If yes, state the type of impairment:

List the major life activities limited by the impairment and describe any limitations (i.e. number of pounds that can be lifted, walking distance, alternate sitting/standing, etc.):

What is the duration or expected duration of the employee's impairment? ______________________

Can the employee perform all job duties listed in the job description? YES NO

If no, state which job functions cannot be performed and why:

Describe any reasonable accommodations that would allow the employee to perform the job functions listed above (if medical leave is one of the possible accommodations, please provide an estimated duration of the leave):

Signature of Healthcare Provider: ______________________ Date: ______________________