PHYSICIAN REQUEST FOR REASONABLE ACCOMMODATION

Please complete the form and return to: [name of district and HR or Section 504/ADA coordinator, address]

Employee/Applicant Name______________________________________

Position Title_____________________________ School/Office_____________________________

A. Identify the employee/applicant's impairment(s) and indicate how the impairment affects his/her ability to participate in the job application process or ability to perform his/her job duties (please be as specific as possible):

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B. State the accommodation(s) necessary to enable the employee/applicant to participate in the job application process or to perform the essential functions of his/her job, and explain how the suggested accommodation(s) will assist the employee/applicant (the position and essential job functions are attached):

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Name of Healthcare Provider Providing Information:_____________________________________

Address:________________________________City/State:__________________Zip:________________

Contact Number:__________________________

Signature________________________________ Date_______________________

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