FILE: GBE-AF
Critical

STAFF HEALTH AND SAFETY
(Accommodations Information Form to Physician)

Pursuant to the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504), the «districtCommonName» will not discriminate against an otherwise qualified individual with a disability in employment.

_____ [name], an employee of the Tri-County RVII, hasrequested accommodation of a disability. The employee has identified the following physical or mental impairment(s): _____
_____
_____
_____

The district requests information about the impairment(s) and related limitations to determine if a legal disability exists and what accommodations are appropriate. The district may not be able to provide appropriate accommodations until this form is completed and returned. Please attach additional information if it will assist the district in determining if a legal disability exists or determining the appropriate accommodations. If you have questions regarding this form or the employee's job duties, please contact _____ [title] at _____ [phone] or _____ [e-mail].

To Be Completed by the Physician/Health Care Provider

1. In your professional opinion, does the employee have the identified impairment(s)?

   G Yes G No

   If yes, please describe the impairment: _____
   _____
   _____

   Please list which specific work-related activities are limited and the manner in which they are limited. (For example, "Employee is substantially limited in walking and can only walk short distances.") _____
   _____
   _____
   _____
   _____

If the impairment is a vision impairment, are the effects of the vision impairment mitigated by the wearing of ordinary eye glasses or contact lenses? G Yes G No

If yes, describe the extent of the limitation when the employee is wearing eyeglasses or contacts.

_____

2. Can the employee perform all of the functions of his or her position without accommodations? G Yes G No

If no, please list the functions the employee is unable to perform or will have difficulty performing and explain the extent and duration of the limitation. _____

_____

_____

_____

_____

3. If you answered no to question 2) above, is the employee able to perform all of the functions of his or her position with accommodations?

G Yes G No

If the employee is unable to perform or will have difficulty performing work-related functions, please provide suggestions on the types of accommodations that would allow the employee to perform these functions: _____

_____

_____

It is my professional opinion that the above information is true and accurate as of the date of my signature.

_____ _____

Physician/Health Care Provider Signature Date

_____ _____

Printed Name Phone Number

Return Form To: Office of Superintendent; Tri-County RVII School District

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Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.

Implemented: 08-06-2007

Revised: 03-11-2010

Tri-County RVII School District; Jamesport MO