

Workplace Accommodation Request

Date: _____

This is a confidential form and will be submitted by the requesting applicant/employee directly to Human Resources. Only employees are expected to complete workplace information.

POSITION INFORMATION

Name: _____	Title: _____
Address: _____	Telephone: _____
Home Phone: _____	School/Department: _____
Supervisor: _____	FLSA/Hours: _____

Nature of Request:

I am applying for employment. The accommodation requested will allow me to participate in the application process for the following position:

I am currently employed by the Town of Hudson/Hudson Public Schools and request a reasonable accommodation.

My specific limitation is: _____. The accommodation I am requesting is described below. (Describe the type of accommodation; if it is a purchasable item, list the model, number, cost and where it can be purchased, etc. suggestions for worksite modifications or specific job duties which may be restructured or shared to facilitate employment). Please attach additional notes, and documentation as needed.

Describe How This Accommodation Will Assist You:

Attach additional notes as needed.

Requested/Suggested Accommodation:

Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job. Please note if this accommodation is time sensitive.

Employee Certification:

I certify that I have a disability or medical condition that requires reasonable accommodation, which will be met by acquiring the equipment, services or work adjustments described above.

Employee Signature

Date

Medical Questionnaire for Accommodation Request

This form is intended to assist the employer in making a determination regarding whether an employee has a disability that qualifies for an accommodation consistent with the Americans with Disabilities Act (ADA). This form must be completed by the treating healthcare provider.

Employee / Patient Information Requesting Accommodation Authorization for Release of Medical Information:

Employee Name (please print)

Date

TO: My Medical Care Provider(s)

You are hereby authorized to give to the **Hudson Public Schools Human Resources Department** all information, facts and particulars which may be requested regarding my medical condition, diagnosis, prognosis, and estimates of disability.

This information is to be used for purposes of evaluating and handling my request for workplace accommodation and for no other purpose, now or in the future.

Employee Signature

Date

For Medical Professional Only:

Have you examined the employee? Yes No If yes, list date of last examination: _____

For reasonable accommodation requests under the ADA, an employee may have a qualifying disability if he or she has a physical or mental impairment that substantially limits one or more major life activities and interferes with the employee's ability to perform essential job functions. The following questions may help determine whether an employee has a disability:

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

If yes, what is the impairment or the nature of the impairment?

Does the impairment or condition in its active state substantially limit a major life activity as compared to most people in the general population? Yes No

Impairment Specifics:

If yes, what major life activity or activities (includes major bodily functions) is/are affected?

Major Life Activities:

Bending	Sleeping	Sitting	Concentrating	Walking	Breathing	Reading
Standing	Speaking	Eating	Lifting	Working	Thinking	Hearing
Reaching	Caring for Self	Interacting with Others	Other: _____			

Major Bodily Functions:

Bladder	Endocrine	Immune	Digestive	Respiratory	Circulatory	Lymphatic
Bowel	Musculoskeletal	Reproductive	Brain	Neurological	Cardiovascular	Organ Operation
Other: _____						

Impairment Duration:

Is the substantial limitation in any of the identified major life activities or bodily functions Temporary Permanent

If temporary, what is the anticipated duration of the impairment? _____

Workplace Accommodation Questions:

An employee with a qualifying disability may be entitled to a reasonable work accommodation. The following questions may help to determine whether an accommodation is needed to assist the employee in performing his or her essential job duties:

Is the employee having trouble performing his or her essential job duties because of the disability? Yes No
(Please see the attached description of essential job functions.)

If yes, which essential job duties are affected by the employee's limitation(s) and how is the employee limited in performing such job duties?

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation unless the accommodation poses an undue hardship. The following questions may help to determine effective accommodation options:

Can the employee perform the essential functions of the job with a reasonable accommodation? Yes No

If yes, what accommodation(s) do you recommend to assist the employee in performing his/her job?

How long does the employee require the recommended accommodation?

Medical Provider Information

**Provider's
Name:**

Address:

State, Zip:

Phone:

email:

Signature:

Date:
