Employee Accommodation Request Form

To be completed by an employee with a medical condition that substantially limits one or more major life activities and is seeking a reasonable accommodation under the Americans with Disabilities Act

Name:
Home Address:
Email Address:
Preferred Phone Number:
Employment Position:
Supervisor's Name:

Please describe the essential responsibilities of your employment position.

What, if any, of these responsibilities are you having difficulty performing?

Please identify and briefly describe the physical and/or mental medical conditions that is affecting your ability to perform your job or access an employment benefit.

Does this physical and/or mental medical condition substantially limit a major life activity? Major life activities include walking, speaking, breathing, hearing, seeing, thinking, sitting, standing, reaching, learning, interacting with others, etc.

Describe how the impairment substantially limits the identified major life activity.

Is the impairment temporary or long term? If temporary, how long is the impairment expected to last?

Have you had an accommodation in the past for this impairment? If so, was the accommodation effective?

What accommodation are you requesting to perform your essential job duties?

How will this accommodation assist you?

Please Read the Following Carefully, Then Sign and Date

I believe I have a disability that may affect my work. I grant the Director of Human Resources permission to explore my coverage and reasonable accommodations under the Americans with Disabilities Act.

I understand that submitting this form is an initial step only, and that I will need to meet with the Director of Human Resources and provide medical documentation in order to move forward with the accommodation process.

I understand that the Director of Human Resources must be able to confirm the existence and extent of my disability and how it affects my ability to perform the duties and responsibilities of my employment position. I understand that this will require me to provide medical documentation and/or authorize contact between my medical provider and the Director of Human Resources.

I understand that the Director of Human Resources will keep medical documentation confidential, and will release such medical documentation only in accordance with the Americans with Disabilities Act or other applicable law.

I understand that if I am granted a reasonable accommodation, this may require disclosure of some information about my impairment to my supervisor or others at Mundelein High School who have a need to know enough about my impairment to assist in providing the accommodations and/or implementing accommodations.

I agree to provide all necessary information and documentation to process my request.

All of the information I have provided on this Employee Accommodation Request Form is complete, accurate, and true to the best of my knowledge.

Employee Signature: _____ Date: _____

Once completed and signed please return this form to the Director of Human Resources at smccreery@d120.org or by hand-delivering or mailing the form to the District Annex Building, 1500 West Hawley Street, Mundelein, Illinois, 60060.