This form should be completed when an applicant or employee has indicated his or her desire to request a reasonable accommodation.

Employee Name: ___________________ Date of Request: __________________

Position: __________________________ Location(s): _______________________

TO BE COMPLETED BY THE EMPLOYEE:

1. Identify and describe the physical or mental disability, illness, condition or disease which is the basis for your request for reasonable accommodation(s):

2. Identify and describe the essential function(s) of your position, which you are unable to perform without reasonable accommodation(s):

3. Identify and describe the reasonable accommodation(s) needed to enable you to properly and safely perform the essential functions of your job, including special equipment, changes in the physical layout of the job, or other accommodations:

4. Identify and describe any special methods, skills or procedures which would enable you to perform the essential functions of your job:

5. Identify and describe any equipment, aids, or services that you are willing to provide and utilize:

6. Identify the names and addresses of physicians, therapists, psychologists, or other health care providers who have information or documentation concerning your disability, illness, condition, or disease or your need for a reasonable accommodation:

Employee’s Signature _______________________________ Date ________________

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“Disability” includes a physical or mental impairment that substantially limits one or more major life activities. Major life activities include such things as caring for oneself, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, breathing, learning, and working.

“Reasonable accommodation” includes any modification to the job or work environment to enable an associate to perform the essential functions of the job in question.

These definitions are provided only as a guide for completing this form. Nothing in this form is intended to alter the legal definitions of these terms or impose obligations on the School District not required by law.
This form should be completed when an applicant or employee has indicated his or her desire to request a reasonable accommodation.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Employee: ___________________________ Date of Birth: __________

Address of Employee: _____________________________________________________

I hereby authorize ____________________________________________________________ to disclose health/medical information as more fully described below, for the purpose(s) listed, to my employer, the Baldwin School District, its employees or agents, including the school physician.

Description:
The information to be disclosed consists of any and all medical/health information related to my request for a reasonable accommodation to a disability.

Purpose:
This information will be used or further disclosed for the following purpose(s):

a) To verify the existence of a disability and consider the need for reasonable accommodation(s) under applicable law;
b) To assist my employer, its employees or agents in the provision of reasonable accommodation(s) to me if it is determined that I am eligible.

This authorization will expire at such time that I am no longer an employee of Baldwin School District. I understand that, with certain exceptions, I may revoke this authorization at any time by sending written notice of the revocation directly to the Assistant Superintendent for Human Resources.

I recognize that the information or records disclosed, once received by Baldwin School District, may no longer be protected by the HIPAA Privacy Rule, but will be kept confidential to the extent required by other applicable federal and state law.

I understand that while I am not required to sign this authorization, failure to do so may prevent my employer from receiving information necessary for its determination of my accommodation request. However, any decision by me not to sign this authorization will not interfere with my ability to obtain health care from my physician or other health care provider, except for health care that is provided solely for the purpose of creating the health information described above for disclosure to Baldwin School District.

I have had the opportunity to review and understand the content of this authorization. A photocopy or faxed copy of this signed authorization shall have the same effect as the original.

_________________________________________ __________________________
Signature of Employee Date
PHYSICIAN'S QUESTIONNAIRE
(All questions must be answered completely and legibly.)

Employee: ____________________________ Date of Birth: ______________

Physician’s Name: ___________________________ Phone: ______________

Physician’s Address: ____________________________

1. On what date(s) did you examine the patient?

2. What is the nature of the employee's physical or mental disability, illness, condition or disease which is the basis for your request for reasonable accommodation(s):

3. What is the anticipated duration of this disability/illness until full recovery?

4. Is the employee presently capable of performing any or all aspects of the employee's job? If not, what are the limitations due to this disability/illness?

5. What, if any, accommodation is needed, and if so, what is the specific nature and projected duration of the needed accommodation?

Physicians' Signature_______________________________________ Date______________________