New Hanover County Schools
Reach, Equip, Achieve

Americans with Disabilities Act (ADA)
Accommodation Request Form

Date:

EMPLOYEE INFORMATION (PART 1)			
Name:		Work site:	
Address:		Position:	
City:		Supervisor:	
State:		Home Phone:	
Zipcode:		Cell Phone:	
EMAIL			

Please provide detailed responses to each question below.

What is the situation or condition that is prompting you to make an accommodation request? (e.g. nature of impairment; chronic or temporary condition, etc.)

Describe the conditions of employment or job responsibilities that would be affected by your accommodation request:

What specific accommodation request(s) are you proposing?

Describe the anticipated length of the accommodation(s) requested.

_____ _____

Signature of EMPLOYEE Date

EMPLOYEE NAME: _____

MEDICAL CERTIFICATION (PART 2)	
Part 2 must be completed by a licensed health care provider for the request to be considered:	
Starting date for the accommodation(s):	
Anticipated end date for the accommodation(s):	
Please state the physical and/or mental impairment that substantially limits one or more major life activity. Also include whether the impairment is a permanent or temporary condition.	

If an employee requires an accommodation, please complete the appropriate sections. Please mark each applicable section and provide as much information as possible.

PHYSICAL ABILITIES: (If applicable to the medical condition.)	**FULL RESTRICTION**	**PARTIAL RESTRICTION**	**NO RESTRICTION**
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating motorized equipment			
Exposure Limitation (Specify):			
Other (please describe):			

COGNITIVE ABILITIES AND SENSORY SKILLS: (If applicable to the medical condition.)	**NOT CAPABLE**	**LIMITED CAPABILITY**	**FULLY CAPABLE**
Thinking/Reasoning			
Concentrating			
Recalling/Recollecting			
Critical decision-making			
Interacting with others			
Alertness			
Following directions			
Speech/Communication			
Visual/Spatial Processing			
Auditory			
Other (please describe):			

Is the employee taking medications that will impact their ability to work? ☐ No ☐ Yes
(If yes, please explain below.)

Signature of Health Care Provider **Date**

Print Name of Health Care Provider **Name of Practice**

Address **City** **State** **Zip Code**

Completed Accommodation Request form (Parts 1 and 2) must be submitted to:

Heather Listebarger, ADA Coordinator
Human Resources Department
6410 Carolina Beach Road
Wilmington, NC 28412
Fax: 910-254-4129
Heather.listebarger@nhcs.net

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