Clayton County Public Schools – Human Resources Department
Request for Reasonable Accommodation Packet (Employee/Physician Packet)

Instructions for Employee

Step 1: Complete the "Employee Accommodation Request" form and the "Employee Authorization for Release of Medical Information" form. Sign and date where indicated.

Step 2: Take the "Employee ADA Medical Certification" form, along with a copy of your job description supplied by the Benefits Department and the "Employee Authorization for Release of Medical Information" form, to the appropriate physician. Request that your physician examine the job description and complete the "Employee ADA Medical Certification" form.

Step 3: You, or your physician, should return of the completed forms (1. The "Employee Accommodation Request" form; 2. The "Employee Authorization for Release of Medical Information" form and the "Employee ADA Medical Certification" form) to the Benefits Department (by personal delivery, mail, or fax).

Clayton County Public Schools
Human Resources - Benefits Department
ATTN: Benefits Manager
1058 Fifth Avenue
Jonesboro, GA 30236
Phone: 770.473.2700
Fax: 770.603.5767

Step 4: Wait for CCPS's Benefits Manager to contact you for an appointment to begin the interactive process of evaluating your request.

NOTES TO EMPLOYEE:

- Clayton County Public Schools will make every effort to reasonably accommodate employees in accordance with the Americans with Disabilities Act of 1990 (ADA), as amended.
- The ADA defines disability as a mental or physical impairment that substantially limits a major life activity, and generally requires accommodation for employees who are qualified to perform their essential job duties and have a disability or have a record of having a disability.

Instructions for Physician

- Review the duties and requirements on the employee's job description
- Fully complete the "Employee ADA Medical Certification" and return it to the employee or directly to CCPS's Benefits Department.

IN CONFIDENCE

Clayton County Public Schools

EMPLOYEE ACCOMMODATION REQUEST FORM

TO BE COMPLETED BY THE EMPLOYEE

Reasonable accommodations may be needed to provide equal access and opportunities to qualified individuals with disabilities. If you are an employee with special needs that are the result of a disability and you believe that reasonable accommodations will assist you in the performance of your job, please complete this form and return it to the districts Human Resources Benefits Department.

EMPLOYEE NAME		Employee ID		HOME PHONE	
JOB TITLE		WORK LOCATION (building)			
DEPT		WORK PHONE			
SUPERVISOR		SUPERVISOR PHONE			

WORK SCHEDULE (DAYS AND HOURS) _____

Please use back of sheet if you need more room to answer any questions listed below.

1. Please describe the physical, mental, or cognitive impairment(s) that limit your ability to do your job.

2. Describe the accommodations you are requesting. Be as specific as possible (i.e. If you are requesting a piece of equipment or a device, please provide description, manufacturer, cost, where to order, etc.)

3. Describe how the requested accommodations will enable you to perform your job.

4. Please provide any other information that might help evaluate your request.

I give Clayton County Public Schools permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate district personnel and/or my health care professional. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.

Signature _____ Date _____

Clayton County Public Schools

EMPLOYEE AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM

TO BE COMPLETED BY THE EMPLOYEE

TO: _____
Name of Medical Provider

_____
Address

_____
City State Zip Code

RE: _____ _____
Name of Patient Birth date or SSN

_____
Address

_____
City State Zip Code

I hereby authorize _____
Medical Provider

to disclose to Clayton County Public Schools, or any other person, including the agency's legal counsel, who is authorized by my employer to handle medical information for ADA purposes any information concerning my physical or mental condition, that are necessary to determine whether I have a disability and to determine whether any accommodations can be made.

I also authorize LaTonya Wilson (Clayton County Public Schools Employee Benefits Manager), or any other person who is authorized by my employer to handle medical information for ADA purposes, to speak to my treating physician or health care provider directly in regards to any questions she may have with respect to my condition that relates to the performance of the essential functions of my job and any accommodations that may be necessary.

I understand that the requested data is for the above-mentioned purposes, and that I may refuse to provide the requested medical information. However, I understand that if I refuse to provide the information, my employer may refuse to provide reasonable accommodation.

This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

_____ _____
Signature of Patient Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family members ought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Clayton County Public Schools

IN CONFIDENCE

EMPLOYEE ADA MEDICAL CERTIFICATION

NOTE: the information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA

To be completed by **EMPLOYEE**

Employee Name		**D.O.B.**		**Employee ID**	
Job Title:		**Department:**			

I authorize my medical provider(s) _____ **to release the following information**

from my patient file to Clayton County Public Schools for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).

Employee Signature:	**Date:**

To Be Completed by the **HEALTHCARE PROVIDER**

INSTRUCTIONS: Attached are copies of the employee's job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. **Please review both the attached job description and job analysis and then complete and sign this form.**

Physician Name:		**Specialization / Type of Practice:**			
Address:		**Fax No:**		**Phone No.:**	

Questions to help determine whether an employee has a qualifying disability. A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

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

2. What is the impairment?

3. Is the impairment permanent? Yes ☐ No ☐

4. If <u>not</u> permanent, how long will the impairment likely last?

5. Is this a condition which:

- **A.** requires periodic visits for treatment by a health care provider? Yes ☐ No ☐
- **B.** continues over an extended period of time? Yes ☐ No ☐
- **C.** may cause episodic rather than a continuing period of incapacity? Yes ☐ No ☐

6. Is the patient taking medications or treatments that would be expected to affect job performance, that would pose a direct threat or safety risk? Yes ☐ No ☐

(See attached job description for statement of duties)

If yes, please explain

7. Does the impairment affect a major life activity? Yes ☐ No ☐

☐ I certify that the employee has a physical, mental, emotional, impairment that limits one or more major life activity. Below, please indicate the life function affected and the limitations of the employee.

Physical Activity	Mild Limitation	Moderate Limitation	Severe Limitation
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Reaching Overhead			
Kneeling			
Pushing & Pulling			
Crouching/stooping			
Lifting or Carrying			
• 10 lbs or less			
• 11 to 25 lbs			
• 26 to 50 lbs			
• 51 to 75 lbs			
• 76 to 100 lbs			
• Over 100 lbs			
Repetitive Use of Hands			
• Right Only			
• Left Only			
• Both			
Simple/Light Grasping			
• Right Only			
• Left Only			
• Both			
Firm/Strong Grasping			
• Right Only			
• Left Only			
• Both			
Fine motor, right hand			
Fine motor, left hand			

To Be Completed by the **HEALTHCARE PROVIDER**

Indicate Level of Mental, Emotional, and Sensory Limitations

Pace of Work	☐ Fast ☐ Avg ☐ Below Avg	Reasoning	☐Mild ☐ Moderate ☐Severe
Manage Multiple Priorities	☐Mild ☐ Moderate ☐ Severe	Hearing	☐Mild ☐ Moderate ☐Severe
Intense Customer Interaction	☐Mild ☐ Moderate ☐Severe	Reading	☐Mild ☐ Moderate ☐Severe
Multiple Stimuli	☐Mild ☐ Moderate ☐Severe	Analyzing	☐Mild ☐ Moderate ☐Severe
Frequent Change	☐Mild ☐ Moderate ☐Severe	Verbal Communication	☐Mild ☐ Moderate ☐Severe
Short-term Memory	☐Mild ☐ Moderate ☐Severe	Written Communication	☐Mild ☐ Moderate ☐Severe
Long-term Memory	☐Mild ☐ Moderate ☐Severe	Vision	☐Mild ☐ Moderate ☐Severe
Attention Span	☐Mild ☐ Moderate ☐Severe		

Questions to help determine whether an accommodation is needed.

1. What limitation(s) in major life activities is/are interfering with this employee's job performance?

2. What essential job function(s) listed in the job analysis is the employee having trouble performing because of the limitation(s)?

3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the essential job functions listed in the attached job analysis?

Questions to help determine effective accommodation options.

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

2. How would your suggestion(s) improve the employee's performance?

Comments.

SIGNATURE of HEALTHCARE PROVIDER: *Stamps and Designee Signatures **NOT** Accepted*	**Date:**

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S FILE.