FILE: GBE-AF
Critical

STAFF HEALTH AND SAFETY
(Accommodations Information Form to Physician)

Pursuant to the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504), the Boonville R-I School District will not discriminate against an otherwise qualified individual with a disability in employment.

_____ [name], an employee of the Boonville R-I School District, has requested accommodation under the ADA and Section 504. The employee has identified the following physical or mental impairment(s): _____
_____
_____
_____

The district requests information about the impairment(s) and related limitations to determine if a legal disability exists and what accommodations are appropriate. The district may not be able to provide appropriate accommodations until this form is completed and returned. Please attach additional information if it will assist the district in determining if a legal disability exists or determining the appropriate accommodations. If you have questions regarding this form or the employee's job duties, please contact _____ [title] at _____ [phone] or _____ [e-mail].

To Be Completed by the Physician/Health Care Provider

1. In your professional opinion, does the employee have the identified impairment(s)?

   G Yes G No

   State the approximate duration of the impairment(s). _____
   _____
   _____

2. Considering any mitigating measures, such as medicine or medical devices used by the employee that may reduce the impact of the impairment, does this impairment limit the employee in one (1) or more of the following activities: caring for one=s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working?

   G Yes G No

If yes, please list all the activities limited and the manner and extent to which they are limited. _____

3. Can the employee perform all of the essential functions of his or her position as articulated in the attached job description without accommodations? G Yes G No

If no, what functions is the employee unable to perform? Please explain why the employee is unable to perform the functions and for how long the employee will be unable to perform these functions. _____

4. If you answered no to question 3) above, is the employee able to perform all of the functions of his or her position with accommodations?

G Yes G No

If yes, please describe the types of accommodations that would allow the employee to perform these functions: _____

It is my professional opinion that the above information is true and accurate as of the date of my signature.

_____ _____
Physician/Health Care Provider Signature Date

Print Name: _____ Phone Number: _____

Return Form To: _____
_____ [title and address]

* * * * * * *

Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.

Implemented:

Boonville R-I School District, Boonville, Missouri