**AMERICANS WITH DISABILITIES ACT**

**REASONABLE ACCOMMODATIION REQUEST**

**HEALTHCARE PROVIDER INFORMATION:**

Attached to this form is the current job description and the essential job functions for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please answer the following questions related to the employee’s condition as it relates to these essential job functions. The employee’s signed release is attached.

The ADA considers a disability as:

1. “ An individual with a physical or mental impairment that substantially limits one or more major life activities of such individual”;
2. “An individual with a record of such impairment” or
3. “An individual regarded as having such an impairment [as defined in the ADA]
* Does the employee have a disability that substantially limits a major life activity? If so please describe the disability and the limitation.
* Does the employee uses any mitigating measures (medications, assistive technologies, etc.)? How do the mitigating measures affect the disability
* Does the disability affect the employee’s ability to perform any one of the essential job functions of the position? [yes or no]? If so, please describe the impact on the person’s ability to perform specific functions. Describe any mitigating measures used.
* In your professional opinion, are there any accommodations that would allow the employee to perform the essential job functions? If so, describe the accommodations.
* Is the need for the accommodation temporary or permanent? If temporary, how long do you estimate the need for the accommodation to exist?

Provider Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional License or Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return to :

Dr. Carol Johnson

Assistant Superintendent

Rappahannock County Public Schools

6 School House Road

Washington, Virginia 22747