JACKSONVILLE SCHOOL DISTRICT 117

211 West State Street, Jacksonville, Illinois 62650
Office: 217-243-9411 Fax: 217-243-6844

RICH HISTORY, BRIGHT FUTURE

ACCOMODATION REQUEST

Healthcare Provider Statement

Dear Doctor_____,

Our employee_____, has requested an accommodation for his/her disability. Please provide us with your advice concerning the employee's current diagnosis relating to his/her disability and any current limitations relating to this diagnosis by responding to the attached questions. Below is an authorization for release of confidential medical information signed by your patient (our employee) authorizing the release of this information to the Jacksonville School District 117. Also, enclosed is a copy of our employee's job description for your review.

Please complete this form in its entirety so that the employee's application for an accommodation can be processed. Please send us your related medical records concerning this employee so Jacksonville School District 117 can determine whether our employee qualifies for an accommodation. Please pay particular attention to Question #8 where you may note any suggestions as to ways to accommodate restrictions that you believe are permanent.

At the bottom of this letter you will see a place for your signature, as well as a date, office address, your specialty, and your office phone number. Please provide this information also. If you have any questions with regard to this request, please do not hesitate to contact me. Your help in evaluating our employee's request is greatly appreciated.

Yours truly,

_____
Tami Stice
Director of Human Resources

RELEASE AUTHORIZATION

Authorization for Release of Confidential Information

I,_____do hereby authorize any healthcare provider of mine who has any records to make available or give to Jacksonville School District 117, its agents, employees, representatives, and/or attorneys any and all information from my medical records pertaining to the condition for which I am requesting an accommodation. I further authorize my healthcare provider to confer with Jacksonville School District 117, or its agents or representatives, or healthcare providers concerning this request for an accommodation.

_____
Employee Signature

_____ _____
Typed or Printed Name Date

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ACCOMODATION QUESTIONARE

1. Date of my most recent examination of employee:_____

2. Current Diagnosis:_____

3. **Yes or No** Does this condition substantially limit a major life activity? A major life activity includes such things as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

   If yes, please identify the major life activity that is limited and explain how the patient has significant restrictions compared to the average person in the general population.

   _____

   _____

4. **Yes or No** Is this condition temporary for which you are treating this patient?

   If yes, how long is this condition expected to last? _____

   Please explain:_____

5. **Yes or No** I have reviewed the job description you provided me for this employee. Based on my review of the job description and my diagnosis of this employee's health condition (disability), it is my opinion a significant health or safety risk is posed to the employee or others if the employee returns to his employment.

6. **Yes or No** The employee is able to return to work without any limitations or accommodations.

7. The date the employee was first restricted and confined to home: _____

   The date the employee is expected to be able to return to work: _____

8. The employee is able to return to work but the following restrictions are recommended:

   - ☐ Walking (please explain) _____
   - ☐ Bending, stooping (please explain) _____
   - ☐ Sitting, standing (please explain) _____
   - ☐ Pushing, pulling (please provide specific weight restriction) _____
   - ☐ Lifting, carrying (please provide specific weight restriction) _____
   - ☐ Exposure (noise, thermal, vibration, etc.) (please explain)_____
   - ☐ Operating equipment (please explain) _____
   - ☐ Other (please explain) _____

Upper Extremity Restrictions

- ☐ Lifting above shoulder height
- ☐ Twisting/grasping
- ☐ Repetitive motion
- ☐ Splint use
- ☐ Other

Lower Extremity Restrictions

- ☐ Kneeling/squatting
- ☐ Crawling
- ☐ Stairs/climbing
- ☐ Crutches/splint

Please explain any restrictions noted above or "other" restrictions:

_____

_____

_____

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ACCOMMODATION QUESTIONARE CONTINUED

9. Nature of Restrictions:
   - ☐ The above-listed restrictions are temporary.
   - ☐ The above-listed restrictions are permanent.
   - ☐ The employee has now reached maximum medical improvement subject to the following:
     - ☐ The employee has permanent restrictions as noted above.
     - ☐ The employee has no restrictions.

I have reviewed the job description you provided me for this employee. In order to accommodate the above listed restrictions and still perform the essential functions of the job, I recommend the following:

10. **Yes or No** The employee may work without restrictions but must work intermittently or work on a reduced work schedule.

    Please specify the nature and probable duration of the need for intermittent leave or the reduced work schedule: _____

    _____

11. **Yes or No** The employee requires treatment for the condition for which I am treating the employee.

    Please specify the nature of the treatment (or a general description of the treatment, i.e., prescription drugs, physical therapy) and the probably duration of the treatment:

    _____

    _____

12. The employee is restricted to very minimal physical activity and is confined to home for the following reasons:_____

    _____

MEDICAL PROVIDERS INFORMATION

_____ _____
Healthcare Provider Signature Healthcare Provider Name (Please type or print)

_____ _____
Healthcare Provider's Specialty Date

_____ _____
Office Phone Fax Number

_____
Office Address