REQUESTING A REASONABLE ACCOMMODATION
(Attachment for Policy No. 104)

How to Request an Accommodation

An employee or third party should request an accommodation in writing directly to the ADA/504 Program Coordinator, Deputy of Employee and Labor Relations in the Office of Talent, Suite 202, 440 North Broad Street.

In the accommodation request, the employee or third party seeking the accommodation should indicate the physical or mental impairment requiring the accommodation, should provide all medical reports supporting the request, should describe the functional limitation, and should provide specific accommodation suggestions.

If an employee or third party requests an accommodation from the building principal/immediate supervisor, building principal/immediate supervisor should refer the employee to the ADA/504 Program Coordinator, and should notify the ADA/504 Program Coordinator in writing of the referral.

Pursuant to Policy 904, third parties seeking an accommodation for access to or participation in public events should be directed to school building principal or the administrative organizer of the district event.

Employees or third parties may not receive the specific accommodations requested, but, if accommodation is possible, he or she will receive a reasonable accommodation that allows the employee to perform the essential functions of his or her position or provides required access to ***third parties***.

Complaint Procedure

All School District Employees who believe that they have been subject to conduct by an employee or third party that constitutes a violation of this policy, Policy 104, may file a complaint using the administrative procedures: Procedures for Filing an Employment Complaint. This same procedure applies to applicants and third parties.

ADA/504 Program Coordinator:
Employee and Labor Relations
440 North Broad Street, Suite 202, Philadelphia, PA 19130
employeerelations@philasd.org
(215) 400-4640

School District of Philadelphia

Application for Reasonable Accommodation
Under The Americans with Disabilities Act or Applicable State or Local Law

Please complete and return this form to the Office of Employee and Labor Relations, accommodations@philasd.org. You may also return this form by fax at (215) 400-4601.

Employee: _____ Position: _____
(Print Name)

Building/Location: _____ Date of Request: _____

Phone Number: _____ EIDN# _____ Email_____

1. Please describe the reasonable accommodation that you are requesting.

_____

_____

_____

_____

2. For how long do you need the reasonable accommodation?

_____

3. If not obvious, please describe the nature of your disability and include or attach any information that will help us understand the nature of your disability and the limits it places upon (a) your ability to perform your current job and/or your ability to enjoy the benefits/privileges of the workplace.

_____

_____

_____

_____

_____

4. List and describe all of the functions of your job that you are unable to perform or need help performing *because of your disability*. If you are requesting an accommodation to allow you to enjoy certain benefits/privileges of the workplace, please describe the benefits/privileges that you are unable to enjoy *because of your disability*. You should supply as much specific detail as possible.

_____

_____

5. Please describe how the requested accommodation will help you perform the functions of your job and be successful in your position.

If necessary, I authorize my health care provider/insurer to release information necessary to evaluate my accommodation request: (Note: Your request may be denied if the School District of Philadelphia does not have sufficient medical information to consider your request.)

Yes ❒ No ❒

Name of Health Care Provider: _____

Phone Number of Health Care Provider: _____

Fax Number of Health Care Provider: _____

Employee Signature Date

Medical Inquiry for Reasonable Accommodation Requests under The Americans With Disabilities Act (ADA) or Applicable State or Local Law

[TO BE FILLED OUT BY HEALTH CARE PROVIDER]

Please complete and return this form to the Office of Employee and Labor Relations, accommodations@philasd.org. You may also return this form by fax at (215) 400-4601.

Employee Name:

_____ Position: _____
(Print Name)

Building/Location:

_____ Date: _____

Questions to help determine whether an employee has a disability.

1. Does the employee have a physical or mental impairment as defined by the ADA? Yes ❒ No ❒
2. What is the impairment? _____
3. Is the impairment long-term or permanent? Yes ❒ No ❒
4. If not permanent, how long will the impairment likely last?

   _____
5. Does the impairment limit the employee's ability to engage in any life activities? Yes❒ No❒
6. If "yes," please indicate which activities (please circle all applicable responses):

Caring for Self	Walking	Hearing	Lifting	Other: (Please describe)
Interacting with Others	Standing	Seeing	Sleep	_____
Performing Manual Tasks	Reaching	Speaking	Concentrating	_____
Breathing	Thinking	Learning	Reproduction	_____
Working in a Class of Jobs	Toileting	Sitting	Eliminating Bodily Waste	_____

7. Please provide a thorough description of how and the extent to which the impairment limits the activity or activities circled above. Attach additional pages if necessary.

_____

_____

_____

_____

Questions to help determine whether an accommodation is needed.

8. What job function(s) is the employee having difficulty performing because of the limitation(s) described in questions 5, 6, and 7 above?

9. How does the employee's limitation(s) interfere with his/her ability to perform the job functions(s) identified in response to question 8?

10. What benefits/privileges of the workplace can the employee not enjoy because of the limitations described in questions 5, 6, and 7 above?

11. How do(es) the employee's limitation(s) prevent the employee from enjoying the benefits/privileges of the workplace identified in the response to question 10?

Questions to help determine effective accommodation options.

12. Do you have any suggestions regarding possible accommodations to assist the employee to perform the job function(s) that (s)he is having difficulty performing and/or allow him or her to enjoy the benefits/privileges of the workplace identified in question 10?

    Yes ❒ No ❒

13. What are those suggestions?

14. Please describe how your suggestions would assist the employee in performing the job functions that (s)he is having difficulty performing as identified in question 8 and/or allow him or her to enjoy the benefits/privileges of the workplace identified in question 10?

Additional Comments:

Medical Professional Signature

Date

Medical Professional Name (printed)

Medical ID #

Address

Phone

City/State/Zip