SAN ANTONIO INDEPENDENT SCHOOL DISTRICT
HUMAN CAPITAL MANAGEMENT

514 W. Quincy St.
San Antonio, TX 78212
www.saisd.net
210.554.8400

Request for Reasonable Accommodation

Employee (or Applicant) Name: _____

Position with School District: _____

Contact Telephone Number: _____

Time Sensitive: Yes ☐ No ☐

Date of Request: _____

Type of Accommodation Requested: (*As much information as possible should be included here. If the accommodation is not known, then provide information that will assist the parties in the interactive process. There is no requirement that the requesting individual complete the form – it can be completed on behalf of the requesting individual.*)

Reason for Request:

Employee Name: (Printed)	Employee Signature:	Dated:
Name of Person: Completing form if different from employee (Printed)	Signature:	Dated:

ADA Accommodation Physician Information Request Form

Employee/Patient: _____ Date: _____

CONFIDENTIAL

PLEASE RETURN THIS FORM TO THE REQUESTING INDIVIDUAL (EMPLOYEE/PATIENT) OR TO THE FOLLOWING INDIVIDUAL AT SAN ANTONIO INDEPENDENT SCHOOL DISTRICT ("SAISD):

SAISD has received a request for accommodations under the Americans with Disabilities Act from the above-named employee/applicant. Additional information is necessary to allow SAISD to determine whether there are reasonable accommodations that can be provided to permit the employee/applicant to perform the essential functions of his or her position. A copy of the job description is attached as well as a form setting forth the accommodations that have been requested thus far. If you have already provided information regarding requested accommodations, then this form is being used to request clarification. The requested information is necessary for the interactive process which may be hindered without the requested information. Therefore, you are asked to complete and return this form as quickly as possible.

Use additional paper if necessary to answer the questions.If you have questions, please contact

_____ at: _____ .

Physician's Name: _____

Contact Number: _____

Is Employee/Applicant substantially limited in any major life activities as a result of a physical or mental impairment? _____ If the answer is YES, Please identify the major life activities that are substantially impaired: _____

Is the physical or mental health condition is episodic in nature? _____

Will the employee/applicant require a reduced leave schedule or leave from work beyond leave otherwise provided? _____

NOTE: If the answer to either of these questions is YES, please include relevant information in your subsequent responses that will assist these needs being addressed through the interactive process.

Review the attached job description and explain whether employee/applicant is either unable to perform any of the essential functions of his/her job as listed in the position description or is limited in his/her ability to do so. Please identify and explain each limitation or inability to perform as well as the expected duration if it is not permanent.

Based upon your knowledge of employee/applicant's condition, are there any accommodations that you believe SAISD could provide that you believe would allow employee/applicant to perform the essential functions of his/her job?

NOTE: Physician's recommendations will be considered as part of the interactive process but are not a verbatim absolute or guarantee.

Physician Name: (Printed)	Physician Signature:	Dated: