Human Resources

Americans with Disabilities Act Reasonable Accommodation Request

FORM CAN BE RETURNED IN-PERSON, VIA E-MAIL to **ERStaff@slps.org OR VIA FAX (**314)244-1739****

Employee Name: _____ Employee Number: _____

Current Position: _____ Assigned School: _____

Notice: Pursuant to the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504), the Company will not discriminate against an otherwise qualified individual with a disability in employment.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you and your physician not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held be an individual or family member receiving assistive reproductive services.

To Be Completed By Employee:

Describe your impairment in detail.

Please specify which essential job function(s) you believe are affected by your impairment.

Describe in detail your requested reasonable accommodation(s) needed in order for you to perform the essential functions of your current position.

Falsification of information provided on this document may lead to disciplinary action up to and including termination.

_____ _____

Employee Signature Date

_____ _____

Employee Personal Email Address Employee Personal Phone Number

CONFIDENTIAL
Medical Information Form

FORM CAN BE RETURNED IN-PERSON, VIA MAIL **toERStaff@slps.org OR VIA FAX (314)**244-1739****

Employee Name: _____

To Be Completed By Physician/Health Care Provider

The above named employee of the St. Louis Public Schools has requested an accommodation in their employment. The employee's job description is attached to this form. The District requests information about the employee's impairment(s) and related limitations to determine if a legal disability exists and what, if any, accommodations are appropriate. 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 ER Staff at (314) 345-4562 or ERStaff@slps.org.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held be an individual or family member receiving assistive reproductive services.

1. Describe the nature and severity of the impairment – please be specific.

2. Describe the duration of the impairment. Describe dates individual has been within care. Please specifically state whether the impairment is temporary or permanent. If the impairment is temporary, what is the expected length of time that the impairment will last? If possible, please indicate specific date that the impairment will resolve and/or anticipated return date for individual.

3. Can the employee perform all of the essential functions of his or her position **without accommodations**?

Yes ☐ No ☐

If no, please list the essential functions the employee is unable to perform or will have difficulty performing and explain the extent and duration of the limitation

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

Yes ☐ No ☐

Please list the types of accommodations that would allow the employee to perform the essential functions identified in response to Question (3) above.

5. Please provide any additional information which you believe will assist the District in determining the nature of the employee's impairment or whether an appropriate accommodation exists.

6. Is the employee scheduled for reevaluation? If so, when?

Date of Next Evaluation

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

Printed Name

Phone Number

Physician/Health Care Provider Address

Fax Number