**STEILACOOM HISTORICAL SCHOOL DISTRICT**
**ADA ACCOMMODATION FORM**

## EMPLOYEE SECTION

| Employee's Name | Department/School |
|---|---|
| **I authorize the release of the information requested below to the Steilacoom Historical School District.** | |
| Employee Signature | Date |

## PHYSICIANS SECTION

### Questions regarding the employee's qualification as disabled:

1. Does the employee have a disability? (defined by state law as an "abnormal physical or mental condition" and by federal law as a "physical or mental impairment that substantially limits one or more major life activities")

2. If the answer to number 1 is yes, what major life activities are substantially limited? (such as walking, sleeping, eating, breathing, learning, talking, working a broad class of jobs)

3. What are the medical facts that support your conclusion?

### Questions regarding the ability to perform essential functions:

4. Have you reviewed the job description and scheduled assignment we sent you? (If no, please take the time to do so now.)

5. Can the employee perform each of the essential functions of the job without accommodation? (Including any specific essential functions about which we have a specific concern, or which do not show up on a job description)

6. If the answer to number 5 is no, specifically identify which essential functions the employee cannot perform without accommodation.

## Questions regarding effective accommodations:

7. If the answer to number 5 is no, what kind of accommodation(s) (if any) will allow the employee to perform the essential job function(s) identified in number 6? Please be specific.

8. Following up on number 7, are these the only accommodations that will allow the employee to perform the essential job function(s)? (Specifically ask about any we may propose which were not mentioned in response to number 7)

9. If not already identified in response to the questions above, does the employee's treatment require accommodation, and if so, what kind? Please be specific.

10. What is the expected duration of the disability? Do you have any expectation as to the timing or nature of changes in the employee's condition that might affect the employee's ability to perform the job or the effectiveness of any accommodations you are identifying? Can you help identify a way to address and communicate about changes that might arise?

| Signature of Physician/Practitioner | Date | Type of Practice *(Field of Specialization, if any)* |
|---|---|---|
| Printed Name: | Phone: | |

*If you have any questions regarding the completion of this form, please contact the Steilacoom Historical School District, Human Resources Department, 253-983-2220.*

This form may be returned via Fax to 253-584-7198, or mailed to:

Steilacoom Historical School District
Human Resources
511 Chambers Street
Steilacoom, WA 98388