Your Right to Reasonable Accommodation

WHAT IS A REASONABLE ACCOMMODATION?

The ADA mandates that effective reasonable accommodations, absent undue hardship, be provided to qualified persons with disabilities, as defined by law, to ensure individuals are provided equal access to any programs, services, or activities of the District, and any benefits and privileges of employment are applied to everyone.

A "*reasonable accommodation*" is any appropriate measure that would enable a qualified individual with a disability to:

- enjoy equal access to the programs, services, or activities of the District;
- access equal employment opportunities, including benefits and privileges; and/or
- perform the essential functions of their job safely and fully, with or without modifications to allow them to do so.

HOW CAN I REQUEST AN ACCOMMODATION?

In accordance with School Board Policy GBA, an individual shall contact the District's ADA Compliance Officer to begin the Interactive Process of requesting and exploring reasonable workplace accommodations. The following guidelines shall apply:

1. The individual shall contact the ADA Compliance Office via e-mail or phone, or complete the appropriate Request Form online at ada@ocps.net detailing the specific challenges, barriers, or accommodations needed.
2. The individual may be asked to provide information from their healthcare provider detailing specific restrictions, limitations, triggers, or other challenges that need to be considered when exploring accommodations.
3. The individual shall participate in discussions about possible accommodation solutions with the District's ADA Compliance Office and be willing to try different forms of accommodation even if it is not the specific accommodation requested.

ADA COMPLIANCE OFFICE
Orange County Public Schools
Office of Legal Services
445 West Amelia Street
Orlando, FL 32801
Direct: (407) 250-6248
Facsimile: (407) 317-3348
Email: ada@ocps.net

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Orange County Public Schools

REASONABLE ACCOMMODATION REQUEST FORM

NOTE: the information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA

To be completed by **EMPLOYEE**

Employee Name		**D.O.B.**		**Employee ID**	
Phone:		**E-mail:**			
Job Title:		**Work Location:**			
Work Schedule:		**Supervisor:**			

Additional Comments:

Questions to clarify accommodation request.

1. What specific accommodation are you requesting?

2. When do you need the accommodation?

3. What, if any, job function are you, or will you have difficulty performing?

4. What, if any, employment benefit are you having difficulty accessing?

5. Have you had any accommodations in the past for this same limitation? If *yes*, what were they and how effective were they?

I authorize my medical provider(s) _____ to release the following information from my patient file to Orange County Public Schools for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).

Employee Signature:	**Date:**

RETURN FORM TO:
ADA COMPLIANCE OFFICE
Orange County Public Schools
Office of Legal Services
445 West Amelia Street
Orlando, FL 32801-1129
Tel: 407-250-6248
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Email: ada@ocps.net

Orange County Public Schools

HIPAA/MEDICAL RELEASE FORM

This release will be submitted to your doctor(s) in the event that additional information is needed regarding the medical condition(s) for which you are requesting reasonable accommodation(s).

EMPLOYEE INFORMAITON	**Employee Name:**	**Date of Birth:**	**Personnel Number:**
	Street Address:		
	City:	**State:**	**Zip Code:**
	Email Address:	**Phone Number:**	
HEALTHCARE PROVIDER INFORMAITON	**Physician Name:**	**Specialization / Type of Practice:**	
	Address:		
	City:	**State:**	**Zip Code:**
	Phone Number:	**Fax Number:**	
	Additional Information:		

I, hereby authorize Orange County Public Schools, to contact the physician listed above to request and obtain all medical information for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).

_____ _____

Signature of Employee **Date**

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S ADA FILE.

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REASONABLE ACCOMMODATION REQUEST FORM

To Be **Completed by the HEALTHCARE PROVIDER**

INSTRUCTIONS TO HEALTHCARE PROVIDER: Please provide additional information regarding the employee's specific restrictions and limitations in order for us to explore reasonable workplace accommodations to allow them the ability to fulfill the essential functions of their job safely and fully, with or without modifications in place. For a general overview of the employee's job duties please refer to their specific job description located at: https://www.ocps.net/departments/human_resources/compensation/job_descriptions

Physician Name:		**Specialization / Type of Practice:**			
Address:		**Fax No:**		**Phone No.:**	
Employee / Patient Name:					

Questions to help determine whether an employee has a qualifying disability. A person has a qualifying disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

1. Does the employee have a physical or mental impairment? Yes ☐ No ☐

2. What is the impairment? _____

3. Is the impairment permanent? Yes ☐ No ☐

4. If not permanent, how long will the impairment likely last? _____

5. Is this a condition which:

- **A.** requires periodic visits for treatment by a health care provider? Yes ☐ No ☐
- **B.** continues over an extended period of time? Yes ☐ No ☐
- **C.** may cause episodic rather than a continuing period of incapacity? Yes ☐ No ☐

6. Is the patient taking medications or treatments that would be expected to affect job performance, which would pose a direct threat or safety risk? Yes ☐ No ☐

If yes, please explain _____

7. Does the impairment affect a major life activity? Yes ☐ No ☐

☐ I certify that the employee has a physical, mental, emotional, impairment that limits one or more major life activity. Below, please indicate the life function affected and the limitations of the employee.

Physical Activity	Mild Limitation	Moderate Limitation	Severe Limitation
Sitting			
Standing			
Walking			
Bending Over			
Climbing			
Reaching Overhead			
Kneeling			
Pushing & Pulling			
Crouching/stooping			
Lifting or Carrying			
• 10 lbs or less			
• 11 to 25 lbs			
• 26 to 50 lbs			
• 51 to 75 lbs			
• 76 to 100 lbs			
• Over 100 lbs			

Physical Activity	Mild Limitation	Moderate Limitation	Severe Limitation
Repetitive Use of Hands			
• Right Only			
• Left Only			
• Both			
Simple/Light Grasping			
• Right Only			
• Left Only			
• Both			
Firm/Strong Grasping			
• Right Only			
• Left Only			
• Both			
Fine motor, right hand			
Fine motor, left hand			

Indicate Level of Mental, Emotional, and Sensory Limitations

Pace of Work	☐ Fast ☐ Avg ☐ Below Avg	Reasoning	☐Mild ☐ Moderate ☐Severe
Manage Multiple Priorities	☐Mild ☐ Moderate ☐ Severe	Hearing	☐Mild ☐ Moderate ☐Severe
Intense Customer Interaction	☐Mild ☐ Moderate ☐Severe	Reading	☐Mild ☐ Moderate ☐Severe
Multiple Stimuli	☐Mild ☐ Moderate ☐Severe	Analyzing	☐Mild ☐ Moderate ☐Severe
Frequent Change	☐Mild ☐ Moderate ☐Severe	Verbal Communication	☐Mild ☐ Moderate ☐Severe
Short-term Memory	☐Mild ☐ Moderate ☐Severe	Written Communication	☐Mild ☐ Moderate ☐Severe
Long-term Memory	☐Mild ☐ Moderate ☐Severe	Vision	☐Mild ☐ Moderate ☐Severe
Attention Span	☐Mild ☐ Moderate ☐Severe		

Indicate Duration

Are the restrictions stated above permanent? ☐ **YES** ☐ **NO**

If NO, what is the approximate duration that these restrictions shall be in place? _____

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REASONABLE ACCOMMODATION REQUEST FORM

To Be Completed by the **HEALTHCARE PROVIDER**

Questions to help determine whether an accommodation is needed.

1. What limitation(s) in major life activities is/are interfering with this employee's job performance?

2. What essential job function(s) is the employee having trouble performing because of the limitation(s)?

3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the essential job functions?

Questions to help determine effective accommodation options.

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are they?

2. How would your suggestion(s) improve the employee's performance?

Comments.

SIGNATURE of HEALTHCARE PROVIDER: *Stamps and Designee Signatures **NOT** Accepted*	**Date:**

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Orange County Public Schools

REASONABLE ACCOMMODATION REQUEST FORM

(FOR INTERMITTENT LEAVE)

To Be **Completed by the HEALTHCARE PROVIDER**

INSTRUCTIONS: The Reasonable Accommodation Request Form ("RARF") shall be used when an employee seeks an accommodation or additional leave protections due to a documented disability. The purpose of this form is to assist the ADA Compliance Officer in determining whether, or to what extent, a reasonable accommodation is required.

Physician Name:		**Specialization / Type of Practice:**			
Address:		**Fax No:**		**Phone No.:**	
Employee / Patient Name:					

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1. Does the employee have a physical or mental impairment? Yes ☐ No ☐

2. What is the impairment? _____

3. Is the impairment permanent? Yes ☐ No ☐

4. If not permanent, how long will the impairment likely last? _____

5. Is this a condition which:

- **A.** requires periodic visits for treatment by a health care provider? Yes ☐ No ☐
- **B.** continues over an extended period of time? Yes ☐ No ☐
- **C.** may cause episodic rather than a continuing period of incapacity? Yes ☐ No ☐

6. Is the patient taking medications or treatments that would be expected to affect job performance, which would pose a direct threat or safety risk? Yes ☐ No ☐

If yes, please explain _____

7. Can periodic visits/appointments be made outside of their contracted work hours? Yes ☐ No ☐

8. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of appointments and/or flare-ups as well as the estimated duration that the patient may need to take leave from work (e.g., 1 time every 3 months lasting a duration of 1-2 days):

Frequency _____times per _____week(s) _____month(s)

Duration: _____hours or _____day(s) per episode

9. Do you have any suggestions regarding possible accommodations that could assist this employee to perform the essential duties of her job? If so, what are they?

Comments.

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S ADA FILE.

SIGNATURE of HEALTHCARE PROVIDER:	**Date:**

RETURN FORM TO: ADA COMPLIANCE OFFICE – Email: ada@ocps.net or Fax (407) 317-3348