Americans with Disabilities Act (ADA)
Employee Accommodation Request Form

This form is being utilized in accordance with the Americans with Disabilities Act-1990 and as amended in 2008 (ADA), in an effort to ensure that every person receives fair treatment and opportunities from the Irving Independent School District. The information provided will be used to assist Irving ISD in determining whether, or to what extent, a reasonable accommodation for an employee with a disability is required to perform one or more essential functions of their job safely and effectively. The information will be treated confidentially. To be eligible for a reasonable accommodation under the ADA, you must be qualified to perform the essential functions of your position with or without an accommodation, and have a qualifying disability that limits a major life function.

Employee Name: _____

Employee ID No: _____ Phone: _____

School/Dept: _____

Position title: _____

Supervisor:_____

What, if any, job functions are you having difficulty performing due to your medical condition?

What, if any, employment benefits (i.e. access to resources or tools) are you having difficulty accessing due to your medical condition?

Describe how your medical condition limits your ability to perform your job or access an employment benefit?

Is your medical condition temporary? _____ Yes _____ No

If yes, how long will your medical condition last?_____

Have you had any accommodations in the past for this same limitation or medical condition? If yes, what were they and how effective were they?

What specific accommodation, if you know, will enable you to perform your job or access an employment benefit?

If you are requesting a specific accommodation, how will that accommodation assist you?

Please provide any additional information that might be useful in processing your accommodation request.

NOTE: If the disability or need for accommodation is not known or obvious, a physician statement or other relevant diagnostic report outlining your condition, limitations, and accommodations required may be requested to consider this request. In addition, your health care provider may be contacted to request additional clarification regarding your condition, limitations, and/or accommodations.

Signature of Employee/Applicant

Date

Return completed ADA Form via hand-delivery, US Mail, Fax, or Email to:

Irving ISD Risk Management Department
2621 West Airport Freeway, Suite 1901
Irving, TX 75062-6020
Fax: 469-646-4320
Email: accommodations@irvingisd.net

THIS SECTION TO BE COMPLETED BY HUMAN RESOURCES CASE MANAGER (if applicable)

_____ Has available FML/TDL
_____ Exhausted all available FML/TDL
_____ Does not qualify for FML/TDL

Date of Modification to Begin: _____