***LAKEPORT UNIFIED SCHOOL DISTRICT***
***[PERSONNEL/HUMAN RESOURCES]***
***REQUEST FOR REASONABLE ACCOMMODATION — EMPLOYEE***

This form must be completed in order for a qualified disabled employee of the Lakeport Unified School District to request reasonable accommodation to perform the essential functions of his/her position or to enjoy privileges or benefits of employment equivalent to nondisabled employees.

Your request for reasonable accommodation will be reviewed in accordance with Board Administrative Regulation 4032 by the personnel administrator, in conjunction with other management staff as appropriate. You will be notified of the District's decision in a reasonable time after this form is received in the Personnel/Human Resources Office.

(This side of form to be completed by employee)

Your name: _____
(please print)

Address: _____

City/State/Zip: _____

Telephone number: (home) _____ (work) _____

Current position: Div/Dept: _____

Reasonable accommodation is required for the following job functions or privileges/benefits of employment:

_____

_____

_____

_____
(Attach additional sheets if necessary)

In order to perform the job functions listed above or enjoy the privileges/benefits of employment, I will need reasonable accommodation, and request that the District do the following: (Describe)

_____

_____

_____

_____
(Attach additional sheets if necessary)

***NOTE:*** In order for your request to be considered, you must attach the District's Medical Verification/ADA form which has been completed by your physician.

*Signature:* _____ *Date:* _____
*(Employee)*

*Return this completed form and the completed Medication Verification/ADA form to: Human Resources/Personnel Office, Lakeport Unified School District, 2508 Howard Avenue, CA 95453 Fax (707) 263-7332.*

**LAKEPORT UNIFIED SCHOOL DISTRICT**
**Authorization to Receive or Release Medical Information**

AUTHORIZATION:

I hereby authorize Dr. _____ of _____
Street Address

_____, _____, _____
City State Zip Telephone Number

to furnish to an agent, designee, or representative of the Lakeport Unified School District the information requested in the District's "Medical Verification/ADA" form for the purpose of making a decision regarding the Patient's reasonable accommodation request.

DURATION:

This authorization shall become effective immediately and shall remain in effect as long as necessary for the Lakeport Unified School District to accomplish the above-stated purpose.

EMPLOYEE/APPLICANT COPY:

I further understand that I have a right to receive a copy of this authorization upon my request. I hereby request a copy of this authorization and by my initials below acknowledge its receipt.

_____ Yes _____ No Initial: _____

SIGNATURE:

Employee/Applicant: _____ Date: _____

Lakeport Unified School District

# Medical Verification

Americans with Disabilities Act

| *To be completed by employee/applicant:* [Please print or type] | |
|---|---|
| Employee's name: | Position: |
| Position Applying For: | |

*To be completed by physician/psychiatrist:* [Please print or type]

The medical information below is requested by Lakeport Unified School District so that the District may evaluate a request for reasonable accommodation made by the above employee/applicant under the Americans with Disabilities Act and related state law ("ADA"). The District seeks information to help it determine whether the employee/applicant has a "covered disability" and the nature and extent of the employee/applicant's "functional limitations." Under the ADA, a "disability" is defined as "a physical or mental impairment which limits one or more major life activities." Examples of major life activities include performing manual tasks, walking, seeing, hearing, speaking, learning, and working.

1. Does employee/applicant have a physical or mental impairment which in your opinion limits one or more major life activities? Yes ___ No ___ *(Do not state the medical cause/diagnosis of the impairment.)*

2. What major life activity or activities are limited?

3. What is the probable duration of the impairment?

4. What functional limitations does the impairment place on the employee/applicant's ability to perform the essential job functions of the position or on the applicant's ability to complete the job application and selection process? (See attached job description/functional job analysis, and other relevant documents, attached hereto. Attach additional sheets if necessary.)

5. In your opinion, would the employment of the above person pose a significant risk of harm to himself/herself/or other persons?
   Yes ___ No ___

6. If your answer to number 5 is "Yes," what is the specific risk involved?

   The duration of the risk?
   The nature and severity of the potential harm?
   The likelihood that the potential harm will occur?
   The imminence of the potential harm?
   What reasonable accommodation(s), if any, could eliminate the risk or reduce it to an acceptable level?

7. Please state any suggestions you may have as to how the employee/applicant can perform the essential job functions of position with accommodation(s) provided by the District or how the applicant can complete the job application and selection process with accommodation(s)? (Attach additional sheets if necessary.)

Note: 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 an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

| Physician/Psychiatrist's Name: | |
|---|---|
| Business Address/Telephone Number: | |
| Signature: | Date: |