

MEDICAL REASONABLE ACCOMMODATION REQUEST FORM

To: Human Resources Director From: _____
Employee

Job Title: _____

Address: _____

Cellphone: (____) _____

1. Please write your specific disability, impairment or medical condition, including pregnancy:

2. Please describe the accommodation(s) you believe are needed to perform the essential functions of your job. (Describe the type of accommodation as follows: specific job duties which may be restructured or shared to facilitate your employment.)

3. Describe how this accommodation will assist you.

4. Please provide the following information. Your physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.
Physician Name: _____
Practice Name: _____
Address: _____
Telephone: _____ Fax: _____

EMPLOYEE CERTIFICATION/AUTHORIZATION

I certify that I have a disability or medical condition that requires reasonable accommodation, which may be met by acquiring the work adjustments described above. I authorize the release of necessary confidential medical information from the above-mentioned regarding my disability to relevant supervisors as deemed necessary by Human Resources. I also attest to the fact that a copy of my job description and Imagine's Americans with Disability Act (ADA) Policy has been given to me, including any state law policies pertaining to my reasonable accommodation request. To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility: I authorize you to release to Imagine Early Learning Centers information on my impairment/disability and recommendations for reasonable accommodations to be used solely for the purpose of evaluating my request for reasonable accommodation. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

Employee Name (Print) *Employee (Signature)* *Date*

Accommodation Denied and Reason for Denial:

Accommodation agreed upon:

HR Director Name (Print) *HR Director (Signature)* *Date*