PGCPS

REQUEST FOR REASONABLE ACCOMMODATIONS

PART I: To Be Completed by Employee

Date of Request: ____________________________

Name: ____ Employee ID: _________________

Work Location: ____ Position: __________________________

Phone Number (Personal): _______________________ Phone Number (Work): __________________________

Email: ____

Supervisor's Name: _________________________________ Supervisor's Position: _________________________

Have you previously filed with our office? (check one) YES NO

If yes, approx. date(s) of filing: ____

Term: (check all that apply, type year) ex. 20XX - 20XX): Summer School Year

Employee Position (check one) 10 month 11 month 12 month

Current Duty Status (check one) Active Duty Leave with pay Leave without pay

Last date of change:______________________________

NATURE OF DISABILITY / IMPAIRMENT

Please provide a brief description of your medical condition, including date of injury/diagnosis, if applicable.

____

____

Please provide your physician with a copy of your job description. Your job description can be found here: https://offices.pgcps.org/compensationandclassification/positions/

POTENTIAL BENEFITS RELATED TO YOUR DISABILITY:

To help us coordinate between the Office of Equity Assurance and other departments within PGCPS, please check all those that apply. This information is for office use only, and is not used to make a determination.

	Intend to Apply for Benefit(s)	Have Applied for Benefit(s)	Currently Receiving Benefit(s)	Previously Received Benefit(s)
Short-Term Disability (STD)				
Long-Term Disability (LTD)				
Workers' Compensation (WC)				

Transition-To-Work (TTW)				
Family Medical Leave (FMLA)				
Sick Leave Bank (SLB)				

PLEASE SUBMIT THIS COMPLETED FORM TO:

Office of Equity Assurance: By email at equity@pgcps.org, by fax at 301-952-6056, or by mail to:

Prince George County Public Schools
Office of Equity Assurance
14201 School Lane, Room 201F
Upper Marlboro, MD 20772

RELEASE OF MEDICAL INFORMATION:
I ______________________________(Name of Employee), give the health care provider listed below permission to disclose my medical information by answering the questions in Part II of this form. I authorize disclosure of this information to my employer, Prince George's County Public Schools ("PGCPS"). I further authorize _____________________________ (Name of Medical Provider) to speak to a member of PGCPS Office of Equity Assurance regarding my request for a reasonable accommodation.

____

Employee Signature Date

TRUTH ATTESTATION:
I certify, under penalty of law, that the statements and information contained in this document is true, accurate and complete. I understand that any falsified information contained in this form can be grounds for termination.

____

Employee Signature Date

All requests for accommodations will be handled in a prompt and expeditious manner. All records of reasonable accommodation will be kept confidential, to the extent possible.

PGCPS grants accommodations on a school-year basis. Renewals of accommodations take place in the summer. If your school placement changes, please notify the Office of Equity Assurance immediately.

PART II: MUST BE COMPLETED BY EMPLOYEE'S TREATING MEDICAL PROVIDER

EMPLOYEES SHALL NOT COMPLETE ANY PORTION OF PART II

Please answer ALL questions completely, sign, and return to:
PGCPS Office of Equity Assurance by email at equity@pgcps.org or by fax: 301-952-6056.

If the form is not completed in its entirety, PGCPS will reach out for full completion. If more space is needed, please use the back or attach pages. PGCPS may require additional information in the future. We hope we can count on your continued assistance. Thank you.

Employee Name: ____

1. **Was the employee's PGCPS job description included with this form?** (check one)

   YES NO

2. **Is the employee currently able to perform all of the functions of his/her position?** (check one)

   YES NO

3. **Is the employee currently able to enjoy all the privileges and benefits of employment?** (check one)

   YES NO

If no, based on the job description, please identify the employee's specific limitation(s) that is/are interfering with job performance or preventing the employee from accessing a privilege or benefit of employment.

____

____

____

____

____

4. **Name of employee's medical condition. Include official diagnosis, if applicable**:

____

5. **Please describe the nature of this employee's medical condition/injury. If more than one impairment is listed, please list duration for each.**

____

____

____

6. How long will the impairment likely last? (*i.e.*, permanent, two weeks, three months). Be specific. If more than one impairment is listed, please list duration for each.

____

____

7. Is the employee's condition episodic (rather than a continuing period of incapacity)? (check one)

YES NO

If yes, please explain the historic and anticipated future frequency. If more than one impairment is listed, please list duration for each.

____

____

8. Do you characterize this medical condition as *(check one):*

- ☐ Mild
- ☐ Moderate
- ☐ Severe

9. Which major aspects, if any, of the employee's daily living are limited by his/her medical condition/injury: *(Check all that apply)*

Major Life Activities:

- ☐ Bending
- ☐ Breathing
- ☐ Caring for oneself
- ☐ Climbing
- ☐ Communicating
- ☐ Concentrating
- ☐ Eating
- ☐ Hearing
- ☐ Interacting with others
- ☐ Learning
- ☐ Lifting
- ☐ Performing manual tasks
- ☐ Reaching
- ☐ Reading
- ☐ Seeing
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Walking

Major Bodily Functions:

- ☐ Bladder
- ☐ Bowel
- ☐ Brain
- ☐ Cardiovascular
- ☐ Circulatory
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinary
- ☐ Hemic
- ☐ Immune System
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Normal cell growth
- ☐ Reproductive functions
- ☐ Respiratory

Other: ____

10. Please check the box below indicating the employee's current return to work status.

☐ Employee may return to work **FULL DUTY (WITHOUT restrictions)** on (_______________).
(continue to question 24) *insert date*

☐ Employee may return to work **WITH Physical Restrictions** on (______________).
(continue to question 11) *insert date*

☐ Employee may return to work **WITH Cognitive/Mental Restrictions** on (_______________).
(continue to question 16) *insert date*

PHYSICAL RESTRICTIONS

11. If any, indicate the employee's PHYSICAL LIMITATIONS/RESTRICTIONS

a. Affected Body Part(s): ________________________ ________________________

Which side of the body? (check one): RIGHT LEFT BOTH

b. Doctor's Recommendations for the Restrictions as outlined below:

Sitting________________ # of hours
Walking_______________# of hours
Standing______________# of hours

Commercial Driving_______________# of hours
Driving a Passenger Car____________# of hours

LIFTING	CARRYING	PUSHING/PULLING
Frequently__________# of pounds	Frequently_________# of pounds	Frequently___________# of pounds
Occasionally_________# of pounds	Occasionally________# of pounds	Occasionally_________# of pounds
Maximum___________# of pounds	Maximum__________# of pounds	Maximum___________# of pounds

(Check the response below based on your clinical recommendation)

BENDING/TWISTING	SQUATTING	CRAWLING	CLIMBING
Not at all	Not at all	Not at all	Not at all
Occasionally	Occasionally	Occasionally	Occasionally
Frequently	Frequently	Frequently	Frequently
Unlimited	Unlimited	Unlimited	Unlimited

KNEELING	SQUATTING	CRAWLING	CLIMBING

Not at all	Not at all	Not at all	Not at all
Occasionally	Occasionally	Occasionally	Occasionally
Frequently	Frequently	Frequently	Frequently
Unlimited	Unlimited	Unlimited	Unlimited

12. What is the start date of these restrictions?_________________ End date? __________________

13. Are there barriers to the employee's ability to return to work that may be resolved with an accommodation? (check one)

YES NO

14. If you answered "yes" to the above question, please list the barriers and recommended accommodation(s) below:

Barriers:

____

____

____

State the recommended accommodations, with specificity, for each reported disabilities and/or restrictions above:

____

____

____

____

15. If the above requested accommodations cannot be granted, are there alternative accommodations that may assist the employee in completing his/her essential job functions? (check one)

YES NO

If yes, please describe?

____

____

____

COGNITIVE/MENTAL RESTRICTIONS

16. Does the employee have any cognitive or mental restrictions? (check one) YES NO

If no, continue to question 20

If yes, please describe:

____

____

17. What is the start date of these restrictions?_________________ End date? __________________

18. Are there barriers to the employee's ability to return to work that may be resolved with an accommodation? (check one)

YES No

If you answered yes to the above question, please list the barriers and recommended accommodation(s) below:

Barriers:

____

____

____

State the recommended accommodations, with specificity, for each reported disabilities and/or restrictions above:

____

____

____

19. If the above requested accommodations cannot be granted, are there alternative accommodations that may assist the employee in completing his/her essential job functions? (check one)

YES NO

If yes, please describe?

____

____

____

TREATMENT

20. Has the treating physician(s) prescribed treatment for this employee: (check one)

YES NO

If yes, please describe the prescribed treatment?

____

____

21. Expected Duration Treatment (time period or expiration date):_______________________________

22. Are there side effects from this treatment that contribute to the employee's need for an accommodation? (check one)

YES NO

If yes, please describe?

____

____

23. Additional Comments:

____

____

____

24. TRUTH ATTESTATION:

I declare under penalty of perjury that I have examined all of the information on this form, and any accompanying statements or forms, and my declaration is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

____ _________________________

Treating Physician's Signature Date

____ (_______)__________________

Treating Physician's Name (Please Print) Work Phone Number

____

Address, City, State, Zip Code

____

Degree/Specialty/Type of Practice