



JACKSONVILLE SCHOOL DISTRICT 117

REQUEST FOR ACCOMMODATION
UNDER THE AMERICANS WITH DISABILITIES ACT (ADA)

I hereby request an accommodation for the following condition diagnosed by my doctor:

Specifically, I am asking for the following accommodation for the condition described above: (Please state the type of accommodation you are requesting, i.e. leave of absence, etc.)

Date of Birth

Social Security Number

Employee Printed Name

Employee Signature

Date

I am treating or have recently treated with the following doctors for the condition listed above, for which I am seeking an accommodation:

Name of Physician

Name of Physician

Address of Physician

Address of Physician

Phone Number

Phone Number

Name of Physician

Name of Physician

Address of Physician

Address of Physician

Phone Number

Phone Number



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Medical Release

Date:

I, _____, hereby authorize the above-listed healthcare providers of mine to release any and all of my medical information related to the above referenced medical condition (or diagnosis) for which I am requesting an accommodation to Jacksonville School District #117, or its agents, representatives, or healthcare providers, necessary to process my request for accommodation, including the release of copies of my medical records related to my condition for which I am seeking an accommodation. I do further authorize my healthcare provider to confer with Jacksonville School District #117, or its agents, representatives, or healthcare providers concerning this request for accommodation.

Employee Printed Name

Employee Signature Date