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