ARLINGTON PUBLIC SCHOOLS
ADA ACCOMMODATION REQUEST PROCEDURES

To provide equal employment opportunities for employees and applicants, Arlington Public Schools (APS) grants workplace accommodations under several State and federal laws, including the Code of Virginia § 2.2-3905.1., Titles I and V of the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008. The law requires an employer to provide reasonable accommodation to an employee or job applicant with a disability unless doing so would cause significant difficulty or expense for the employer. A reasonable accommodation is any change in the work environment (or in the way things are usually done) to help a person with a disability apply for a job, perform the duties of a job, or enjoy the benefits and privileges of employment. Workplace accommodations are granted in order to allow employees to perform the essential functions of their jobs. Accommodations may include but are not limited to restrictions regarding physical activity, equipment purchases, altered work schedules, unpaid leaves of absence, and as a last resort, job reassignments.

The Division of Employee Relations receives and processes ADA accommodation requests for APS employees. If you have a disability and believe you need a workplace accommodation, you may apply for an ADA accommodation as follows:

1. Employees may request a "reasonable accommodation" by submitting an ADA Accommodation packet, which includes the Americans with Disabilities Act Request Form and a Medical Inquiry Form. Completed forms must be submitted to the APS Division of Employee Relations.

2. An Employee Relations Specialist reviews the completed forms, and the "interactive process" is initiated. This process may include, but is not limited to, any or all of the following:

   a. Discussing the request with the employee;
   b. Reviewing job specification/description/essential functions;
   c. Obtaining additional medical information;
   d. Consulting with the supervisor, human resources personnel, and/or appropriate others; and
   e. Visiting the worksite.

3. An individualized accommodation plan will be created if the request is granted. Employee and administrator/supervisor will receive written documentation of accommodations. Documentation will also be sent to the employee and the supervisor if the request is denied.

4. Employees must notify the Division of Employee Relations if there are any problems with the accommodations or if any changes in accommodations are needed.

5. Accommodation records are maintained in the Division of Employee Relations for all APS employees.

AMERICANS WITH DISABILITIES ACT ACCOMMODATION REQUEST FORM

(Confidential Evaluation to be completed by the employee)

APPLICATION

INSTRUCTIONS Complete the information below, attach the requested documentation, and submit it to the Division of Employee Relations by interoffice mail (marked confidential), U.S. mail: 2110 Washington Blvd, Suite 400, Arlington, VA 22204, email at apsada@apsva.us or (703) 228-6137.

EMPLOYEE INFORMATION

Name: _____ Employee ID Number: _____

Job Title: _____ Work Location: _____

Email Address: _____ Telephone Number: _____

Supervisor/Principal: _____

DISABILITY OR MEDICAL LIMITATIONS (Explain carefully. Use additional paper if necessary. Please attach the enclosed Medical Inquiry Form after your healthcare provider completes it.)

ACCOMMODATION REQUEST *(Confidential Evaluation)*

Does your medical condition require a special work assignment? Yes No
If yes, explain below.

What is the accommodation you are requesting? (*Be Specific*)

APPLICATION CERTIFICATION: I certify that all statements and answers I provided on this form are complete and true to the best of my knowledge. I understand that any falsification of my medical history or request may be cause for discharge. I understand that any personal medical history and fitness revealed as a result of this request for a reasonable accommodation will be treated as Confidential, will be maintained in a medical-specific file, and shall not be released to third parties outside of the Arlington Public Schools without my written authorization.

_____ _____

Signature of Applicant Date

I further authorize the release to Arlington Public Schools of any information from my medical records which is considered pertinent to my accommodation request.

_____ _____

Signature of Applicant Date

MEDICAL INQUIRY FORM
FOR AMERICANS WITH DISABILITIES ACT (ADA) ACCOMMODATION REQUEST
(To be completed by Healthcare Provider)

RETURN COMPLETED FORM TO: The Division of Employee Relations, 2110 Washington Blvd, Suite 400 or email at apsada@apsva.us or (703) 228-6137

Employee's Name_____ **Job Title** _____

A. QUESTIONS TO HELP DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY

A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. The following questions may help determine whether an employee has a disability:

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

What is the impairment? _____

Is the impairment long-term or permanent? ☐ Yes ☐ No
If *not* permanent, how long will the impairment likely last? _____

Does the impairment affect a major life activity? ☐ Yes ☐ No

If *yes*, what major life activity(s) is/are affected?

☐Caring for Self	☐Walking	☐Hearing	☐Lifting
☐Interacting with Others	☐Standing	☐Seeing	☐Sleeping
☐Performing Manual Tasks	☐Reaching	☐Speaking	☐Concentrating
☐Breathing	☐Thinking	☐Learning	☐Working
☐Bending	☐Sitting	☐Reading	☐Eating

☐Other: _____

Is the employee substantially limited in one or more of these major life activities? ☐ Yes ☐ No

B. QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Which of the major life activities selected are interfering with the employee's ability to perform the job functions?

What job function(s) is the employee having trouble performing because of the limitation(s)?

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

C. QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Please state any suggestions regarding possible accommodations to improve the employee's ability to perform his/her job.

How would your suggestions improve the employee's ability to perform the job functions?

D. ADDITIONAL COMMENTS

Physician's Name (*Please Print)* _____

Physician's Signature: _____ **Date:** _____

Physician's Phone Number: _____ **Physician's Fax Number:** _____