



Department of Human Resources

**FAIRFAX COUNTY
PUBLIC SCHOOLS**

Office of Equity and Compliance
8115 Gatehouse Road
Falls Church, VA 22042
571-423-3050

Dear Employee:

Under the Americans with Disabilities Act (ADA) you may be entitled to reasonable accommodation to assist you in performing your job. The ADA defines “disability” as a physical or mental impairment that substantially limits a major life activity. Walking, seeing, hearing, speaking, breathing, sleeping, sitting, and performing manual tasks are considered to be major life activities, and there are many more.

To help us determine whether your medical condition constitutes a disability as defined by the ADA and, if so, whether reasonable workplace accommodations can be provided, FCPS requires verification of your medical condition by a doctor. Therefore, it is important that you and your physician complete the attached form and return it to the **Office of Equity and Compliance, Department of Human Resources, 8115 Gatehouse Road, Suite 2100, Falls Church, VA 22042**. You may **fax** the completed form to **571-423-3057**.

If you have questions, please call the Office of Equity and Compliance at 571-423-3050.

Thank you.



REQUEST FOR MEDICAL ACCOMMODATIONS

Fairfax County Public Schools
Department of Human Resources
OFFICE OF EQUITY AND COMPLIANCE
8115 Gatehouse Road, Falls Church VA 22042
Telephone: 571-423-3050/FAX: 571-423-3057

TO BE COMPLETED BY EMPLOYEE:

Name: _____ Employee ID Number: _____
Position: _____ Work Location: _____
Telephone Number: (Work) _____ (Home) _____

Major job responsibilities (may require confirmation by supervisor): _____

I am currently receiving through FCPS FMLA Short-term Disability Benefits
(check as many as apply): Workers' Compensation Benefits Long-term Disability Benefits

RELEASE OF INFORMATION (Optional):

If additional medical information is required, Fairfax County Public Schools has my permission to contact the physician completing this form.

Employee Signature

Date

TO BE COMPLETED BY EMPLOYEE'S PHYSICIAN:

Please use the back of this form if additional space is needed to complete your responses.

- Name of employee's medical condition: _____
- Please describe the nature of this employee's medical condition: _____
- How long has the employee had this condition and how long is it expected to last? _____
- How would you characterize this medical condition (i.e. mild, moderate, severe)? _____
- List the major activities of daily living that are limited by this employee's medical condition, if any: _____
- List the work functions that the employee is unable to perform because of his or her medical condition, if any: _____
- Given the limitations cited above, what could FCPS do to assist the employee to perform his or her job duties? _____
- Are there any alternative ways to assist him or her? _____
- Have you prescribed treatment for this employee? If so, please describe the treatment(s): _____
- Are there side effects from this treatment that contribute to the employee's request for accommodation? If so, please describe them: _____
- Identify those activities listed in #5 and #6 above that the employee can perform with the treatment you identified in #9. _____
- Was an FCPS Job Specification sheet included with this form: YES NO. If yes, please review it and identify any of the functions you believe the employee cannot perform, and why, unless you already have done so in response to an earlier question. _____

Physician Signature _____ Date _____

Physician Name (Please Print): _____

Street Address: _____

City/State/Zip Code: _____

Telephone Number: _____