REQUEST FOR REASONABLE ACCOMMODATIONS

PART I: To Be Completed by Employee:

Name: _____ Employee ID: _____

Work Location: _____Position: _____

Phone Number (Personal): _____ Phone Number (Work): _____

Email: _____

NATURE OF DISABILITY / IMPAIRMENT
Please provide a brief description of your medical condition.

Date of Injury (DOI), if applicable: _____

Date of Disability Onset (DOD), if applicable: _____

POTENTIAL BENEFITS RELATED TO YOUR DISABILITY:
To help us coordinate between the Office of Benefits Services (Disability and Leaves Unit) and the **Office of Equity and Employee Relations (EER)**, please check all those that apply:

	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)				
Family Medical Leave (FMLA)				

PLEASE SUBMIT THIS COMPLETED FORM TO: SEDGWICK or MetLife AND TO FCPS EER

Equity & Employee Relations: By fax at 571-423-5051 or by email at EERADA@fcps.edu
Sedgwick: For Short Term Disability (STD) to by fax at 859-264-4384 or by email at claiminfo@sedgwickcms.com. Workers' Compensation (WC) claims by fax at 804-673-5400
MetLife: For Long Term Disability (LTD) claims call 800-243-8786.

RELEASE OF MEDICAL INFORMATION:
Sedgwick and MetLife are a third-party administrator that works with FCPS to provide STD, LTD and WC benefits. Information you provide to Sedgwick and MetLife may also inform your entitlement to other potential benefits, such as FMLA leave, or reasonable accommodations under the Americans with Disabilities Act (ADA). Please confirm, by signing below, that Sedgwick and MetLife may provide FCPS with copies of any medical forms or documentation you provide to it. Any such information received by FCPS will be kept confidential and stored apart from personnel files, and used only as permitted by law.

_____

Employee Signature Date

Treating Provider Form: With or Without Restrictions
REQUEST FOR REASONABLE ACCOMMODATIONS

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

Please answer ALL questions completely, sign, and return to: **FCPS Office of Equity & Employee Relations (EER)** by Fax: 571-423-5051 or by email at EERADA@fcps.edu For Short Term Disability and Workers' Compensation Claims to Sedgwick by fax at 859-264-4384 or by email at claiminfo@sedgwickcms.com - Customer Service Number at 855-937-1387; and for Long Term Disability Claims call MetLife at 800-243-8786.

If more space is needed, please use the back or attach extra pages. FCPS, Sedgwick and/or MetLife may requireadditional information in the future. We hope we can count on your continued assistance. Thank you.

FCPS Employee Name: _____

1. Name of employee's medical condition:

_____

2. Please describe the nature of this employee's medical condition/injury:

_____

_____

3. How long (a) has the employee had this condition/injury and (b) is it expected to last?

(a) _____ (b) _____

4. Do you characterize this medical condition as *(circle one):* Mild, Moderate, or Severe?

5. Which major aspects, if any, of the employee's daily living are limited by his/her medical condition/injury:
(Circle all that apply)
Major Life Activities: *caring for oneself *performing manual tasks *seeing *hearing *eating *sleeping *walking *standing *lifting *bending *speaking *breathing *learning *reading *concentrating *thinking *communicating *working
Major bodily functions:*the immune system *normal cell growth *digestive *bowel *bladder *neurological *brain *respiratory *circulatory *endocrine *reproductive functions
Other
_____

6. Please check the box below to confirm the employee's current return to work status.

☐ Employee may return to work FULL DUTY (WITHOUT restrictions) on (_____)
insert date

☐ Employee may return to work WITH Physical Restrictions on (_____) (***Complete Next Sections***)

☐ Employee may return to work WITH Cognitive/Mental Restrictions on (date _____) (***Same***)

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

Limited Use of Affected Body Part(s): _____ Right Left Both

Restrictions as outlined below:

Sitting: _____ hours
Walking: _____ hours
Standing: _____ hours

Commercial Driving: _____ hours
Driving a Passenger Car: _____ hours

Lifting:	Carrying:	Pushing/Pulling
Frequently _____ pounds	Frequently _____ pounds	Frequently _____ pounds
Occasionally _____ pounds	Occasionally _____ pounds	Occasionally _____ pounds
Maximum _____ pounds	Maximum _____ pounds	Maximum _____ pounds

Bending/Twisting	Squatting	Crawling	Climbing	Kneeling	Reaching
☐ Not At All	☐ Not At All	☐ Not At All	☐ Not At All	☐ Not At All	☐ Not At All
☐ Occasionally	☐ Occasionall	☐ Occasional	☐ Occasionall	☐ Occasionall	☐ Occasional
☐ Frequently	☐ Frequently	☐ Frequently	☐ Frequently	☐ Frequently	☐ Frequently
☐ Unlimited	☐ Unlimited	☐ Unlimited	☐ Unlimited	☐ Unlimited	☐ Unlimited

Working at Heights	Operating machinery	Exposure to Dust/Fumes/Gas
☐ Not At All	☐ Not At All	☐ Not At All
☐ Occasionally	☐ Occasionally	☐ Occasionally
☐ Frequently	☐ Frequently	☐ Frequently
☐ Unlimited	☐ Unlimited	☐ Unlimited

What is the start date of these restrictions? _____ End date? _____

Are there barriers in the employee's ability to return to work that may be resolved with an accommodation?
Y / N

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

Barriers:

_____

Recommended accommodation(s):

_____

_____

What is the expected start and end dates of these recommended accommodations?
From _____ to _____.
Insert date *Insert date*

8. If any, indicate the employee's COGNITIVE/MENTAL RESTRICTIONS

Does employee have any cognitive or mental restrictions? Y / N If yes, please describe:

_____

_____

What is the start date of these restrictions? _____ End date? _____

Are there barriers in the employee's ability to return to work that may be resolved with an accommodation? **Y / N** If you answered yes to the above question, please list the barriers and recommended accommodation(s) below:

Barriers:

_____

Recommended accommodation(s):

_____

_____

What is the expected start and end dates of these recommended accommodations?
From _____ to _____.
Insert date *Insert date*

9. An FCPS Job Specification sheet was 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, then please identify the applicable question number).

_____

_____

10. Given the limitations cited above, what could FCPS do to assist the employee to perform his or her job functions?

_____

_____

11. Are there any alternative ways to assist the employee? Y / N If yes, what?

_____

_____

12. Has the treating physician(s) prescribed treatment for this employee (circle one): Y / N If so, describe it:

_____

Expected Duration (time period or expiration date):

_____

13. Are there side effects from this treatment that contribute to the employee's need for an accommodation?

Circle one: Y / N If so, please describe them:

_____

_____

Additional Comments: _____

_____

Treating Physician's Signature

Date

_____

Treating Physician Name (Please Print)

(_____)_____-_____

Work Phone Number

_____

Address, City, State, Zip Code

MANAGER INSTRUCTIONS

If an employee has submitted a disability claim, managers may contact Sedgwick via web portal www.mysedgwick.com or via phone at 855-937-1387 to confirm an employee's status. Per FCPS protocol, employees may not return to work unless as part of the reasonable accommodations process through EER or until Sedgwick forwards information contained in this form or a signed full duty release. If you have not received an email from Sedgwick with the information contained in this form and have received this form directly from the employee or treating physician, please provide a copy of this form to EER and contact Sedgwick 855-937-1387 to confirm the employee's status and discuss next steps. (REVISED 07/2021)