**REQUEST FOR MEDICAL ACCOMMODATIONS**
**Fairfax County Public Schools (FCPS) - Department of Human Resources**
**OFFICE OF BENEFITS SERVICES (Disability and Leaves Unit)**
**OFFICE OF EQUITY AND EMPLOYEE RELATIONS (EER)**
**8115 Gatehouse Road, Falls Church, VA 22042**
**Telephone: 571-423-3070/FAX: 571-423-3057**

Name: _____ Employee ID Number: _____
Position: _____ Work Location: _____
Telephone Number: (Work) _____ (Home) _____
Nature of Disability: _____
Major Job Responsibilities (may require confirmation by supervisor): _____
_____

I am currently receiving or have received the following benefits through FCPS: (check as many as apply)
____Short-Term Disability ____Long-Term Disability ____Workers' Compensation ____FMLA

Date of Injury (DOI): _____ Date of Disability (DOD): _____

**Release of Medical Information on file with Liberty Mutual: If additional medical information is required, FCPS has my permission to contact the physician completing this form.**
**Employee Signature _____ Date_____**

**TO BE COMPLETED BY EMPLOYEE'S PHYSICIAN**:
1. Name of employee's medical condition: _____

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

3. How long has the employee had this condition/injury and how long is it expected to last? _____

4. How does the treating physician(s) characterize this medical condition (i.e., mild, moderate, severe)?

5. List the major activities of daily living that are limited by this employee's medical condition/injury, if any:

6. List the job functions that the employee is unable to perform because of his or her medical condition/injury, if any: _____

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

8. Are there any alternative ways to assist the employee?_____

9. Has the treating physician(s) prescribed treatment for this employee? If so, please describe it and attach a copy of the FCPS Fitness for Duty Certificate: _____
_____

10. Are there side effects from this treatment that contribute to the employee's (need) for an accommodation? If so, please describe them: _____

11. Identify those job functions listed in # 5 and # 6 above that the employee can perform with the treatment you identified in # 9. _____

12. 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. _____

**Physician's Signature**_____**Date**_____
**Physician Name (Please Print)**_____**Phone #**_____
Street Address_____
City, State, Zip Code_____
Liberty Mutual Claims Manager's Contact: _____

**FCPS MAY REQUIRE ADDITIONAL MEDICAL INFORMATION AND/OR NEED YOUR INPUT IN IDENTIFYING OTHER ACCOMMODATIONS. WE HOPE WE CAN COUNT ON YOUR CONTINUED ASSISTANCE.**