

# BALTIMORE CITY PUBLIC SCHOOLS

**Catherine E. Pugh**  
Mayor, City of Baltimore

**Cheryl A. Casciani**  
Chair, Baltimore City Board of  
School Commissioners

**Dr. Sonja Brookins Santelises**  
Chief Executive Officer

## **INSTRUCTIONS ON REQUESTING AN ACCOMMODATION UNDER THE AMERICANS WITH DISABILITY ACT**

If you have a physical or mental disability that requires modifications or adjustments to your work environment, or to the manner or circumstances under which your job is customarily performed, you have the right to request reasonable accommodations that would enable you to perform the essential functions of your job. This will be an interactive process to explore the most reasonable way to accommodate your needs.

You will submit two Forms: the Reasonable Accommodations Request Form and the Authorization for Release of Employee Medical Documentation. Please note that in order to process your request for accommodations, EEO and Title IX Compliance will likely need to obtain medical information from your physician(s). Therefore, it is imperative that you complete and sign the Authorization for Release of Employee Medical Documentation. *Please understand that failure to provide such authorization to EEO and Title IX Compliance may result in a denial of your request for a reasonable accommodation.*

After you file the request, several steps will be taken:

- Your physician(s) will be contacted to determine whether you have a disability covered by the law.
- If it is determined that you have a covered disability, there will be an interactive process between this office, you and your supervisor, and possibly Human Capital to determine what accommodations (if any) can be made to allow you to perform the essential functions of your job.
- Accommodations will apply during the school year in which they are granted and may reviewed annually by the EEO Office.

Your request will be processed as quickly as possible. However, please be advised that this process can take some time.

During the pendency of this process, you are required to keep EEO and Title IX Compliance informed of any changes in your status. Such changes in status include: school or department reassignment, changes in contact information, leave status or a change in your medical condition.

# EQUAL EMPLOYMENT OPPORTUNITY AND TITLE IX COMPLIANCE

## AMERICANS WITH DISABILITIES ACT (“ADA”) REASONABLE ACCOMMODATIONS REQUEST FORM

Today’s Date: \_\_\_\_\_

Employee’s Name: \_\_\_\_\_

Employee ID No.: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Employee’s Date of Birth: \_\_\_\_\_

Employee’s Home or Personal Telephone Number: \_\_\_\_\_

Employee’s Personal Email Address: \_\_\_\_\_

Employee’s Home Address: \_\_\_\_\_

\_\_\_\_\_

Employee’s Position: \_\_\_\_\_

Employee’s Current School/Office: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Immediate Supervisor’s Title: \_\_\_\_\_

Immediate Supervisor’s Phone Number: \_\_\_\_\_

**Please answer the following questions as fully as possible. If you need more space please write your answers on a separate sheet of paper.**

1. Please identify your medical condition(s)/impairment(s) for which you are seeking an accommodation:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Under the ADA, to be eligible for an accommodation your medical condition(s)/impairment(s) must **substantially limit** one or more major life activities, including, but not limited to, walking, breathing, speaking, seeing, hearing, sitting standing, lifting, etc.

2. How does your medical condition(s) or impairment(s) limit any major life activity?

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3. Please state how long your medical condition(s)/impairment(s) is expected to last:

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4. What **specific** job duties are affected by your medical condition(s)/impairment(s)?

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5. What types of accommodations do you believe would enable you to perform the essential functions of your job?

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6. In order to effectively evaluate your eligibility under the ADA, we will need to request information from your health care providers regarding your medical condition(s)/impairment(s). Please list the name and contact information for each provider who has knowledge of you medical condition(s)/impairment(s).

Physician Name	Hospital/Clinic Name	Address	Phone Number	Fax Number
1.				
2.				
3.				

4.				
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7. Have you previously requested Reasonable Accommodations? Yes \_\_\_ No \_\_\_

8. If you responded “yes” to **Question 7**, please state whether you were granted accommodations and, if so, the date those accommodates were granted:

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9. If you responded “yes” to **Question 8**, please state what accommodations were granted:

\_\_\_\_\_

10. If you responded “yes” to **Question 7**, has your condition changed since you previously made the request for accommodations? Yes \_\_\_ No \_\_\_

11. If you responded “yes” to **Question 10**, please state how your condition has changed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have any additional attached pages, please sign and date them. The number of supplemental pages attached to this form is \_\_\_\_ (If there are no attached supplemental pages please write “0”).

**The foregoing request contains all of the relevant information that is accurate, factual and complete. Any incomplete, misleading or false information submitted as a part of this request may be cause for denial of a request for an accommodation.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Please return this form, the Reasonable Accommodations Request Form, the Authorization for Release of Employee Medical Documentation and, any supplemental pages to:

EEO and Title IX Compliance  
Attn: EEO Manager  
200 E. North Avenue, Room 208