REQUEST FOR REASONABLE ACCOMMODATION
(For CPS Employees, Parent/Guardians, Volunteers, Contractors and Consultants)

AMERICANS WITH DISABILITIES ACT (ADA)
REQUEST FOR REASONABLE ACCOMMODATION

HEALTHCARE PROVIDER CERTIFICATION

Patient's Portion:

I hereby authorize Chicago Public Schools, or its agent, to receive and obtain all medical information related to the current health condition(s) for which I am requesting a reasonable accommodation.

Patient's Name: _____

Employee ID Number (if applicable): _____

_____ _____
Patient's Signature Date

Healthcare Provider's Portion:

Date: _____

Health Care Provider's Name: _____

Your patient has requested that the Chicago Public Schools (CPS) provide reasonable accommodation(s) so that they can perform the essential functions of their job. It is necessary that you provide the following information within thirty (30) days from the date at the top of this form so that CPS can determine whether this person is an *Individual with a Disability* as defined by the Americans with Disabilities Act (ADA).

Patient's Name: _____
Last Name First Name Middle Initial

Date of Birth: _____

If relevant to the situation: Height: _____ Weight: _____

IMPORTANT NOTICE REGARDING GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. *Genetic Information*, as defined by GINA, includes an individual's family medical history, the result of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

CONFIDENTIAL - All information provided is only for use by the ADA Office. For CPS employees, diagnosis and treatment information gathered will not be shared with supervisors and this document will not be added to Personnel Files.

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1. Please confirm that you have been treating the patient and that you are familiar with their medical history:

   ___ Yes ___ No

2. When did the condition(s) begin and how long have you been treating your patient?

3. What accommodations are you recommending for your patient?

4. What is the diagnosis and ICD-10 Code for the condition(s)?

5. Please list and describe the patient's physical or mental impairments.

A physical or mental impairment under the ADA is:

- Any physical disorder, condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic, and lymphatic, skin, and endocrine; *or*
- Any mental or psychological disorder, such as an intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

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6. Which major life activities are limited by the patient's impairments (select all that apply):

General Activities

☐ Bending	☐ Interacting with others	☐ Seeing	☐ Walking
☐ Breathing	☐ Learning	☐ Sitting	☐ Working
☐ Caring for Self	☐ Lifting	☐ Sleeping	☐ Other(s), please describe:
☐ Concentrating	☐ Performing Manual Tasks	☐ Speaking	
☐ Eating	☐ Reaching	☐ Standing	
☐ Hearing	☐ Reading	☐ Thinking	

and/or Operation of Major Bodily Functions

☐ Bladder	☐ Endocrine	☐ Neurological	☐ Sensory Organs & Skin
☐ Bowels	☐ Genitourinary	☐ Normal Cell Growth	☐ Other(s), please describe:
☐ Brain	☐ Hemic	☐ Operation of an Organ	
☐ Cardiovascular	☐ Immune	☐ Reproductive	
☐ Circulatory	☐ Lymphatic	☐ Respiratory	
☐ Digestive	☐ Musculoskeletal		

7. How does the patient's medical condition(s) or impairment(s) limit their ability to perform their job functions? Please provide as much detail as possible.

Whether an impairment substantially limits the ability of an individual to perform a major life activity is determined:

- As compared to most people in the general population; and
- Does not need to prevent, or significantly or severely restrict the individual from performing a major life activity - the impairment only needs to "substantially limit" the individual's ability to perform the major life activity
- When listing impairments, please consider the disorder:
  - In its active state, even if presently in remission (examples: epilepsy, MS, asthma, cancer, bipolar disorder)
  - Without regard to the effects of mitigating measures such as prostheses, medication, etc. (with the exception of ordinary eyeglasses)
  - With consideration of the negative effects of treatment such as medication or other measures

8. What is the patient's prognosis for each impairment and/or condition? Are the conditions or impairments permanent or temporary? If the condition is temporary in nature, when do you anticipate the need for accommodations will end?

9. Are there any other medical providers assisting with treatment? If so, please provide their contact information.

10. Is there any other information of which CPS should be made aware regarding the requested accommodation(s)? If so, please provide.

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HEALTHCARE PROVIDER CERTIFICATION
For use by Health Care Provider Only

I, the undersigned Health Care Provider, certify that the information provider concerning _____, the above-named patient, is complete, and accurate to the best of my knowledge. In signing this form, I agree to answer, in a timely manner, any question that CPS may have about the basis of the statements made on this form. I understand that my cooperation is necessary for CPS to make an accurate decision on my patient's request for reasonable accommodation under the Americans with Disabilities Act.

_____ _____
Health Care Provider's Signature Date

_____
License Number

_____
Print Name

_____
Type of Practice

_____
Address

_____
City State Zip Code

_____
Phone Fax Email

Please return this form to:

Chicago Public Schools ADA Office
2651 W Washington Blvd, Suite 255
Chicago, IL 60612
Email: ada@cps.edu Fax: (773) 553-1091
Phone - Voice: 773-553-1013, Option 2

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