INSTRUCTIONS FOR COMPLETING THE AMERICANS WITH DISABILITIES INTAKE APPLICATION FOR INTERACTIVE MEETING PROCESS

The Americans with Disabilities Act (ADA) definition of an individual with a disability is very specific. A person with a "disability" is defined as an individual who:

- *has a physical or mental impairment that substantially limits one or more of his/her major life activities; (examples of major life activities include, but are not limited to, seeing, hearing, lifting, walking, learning, working or performing manual tasks)*
- *has a record of such an impairment; or,*
- *is regarded as having an impairment.*

The ADA prohibits employment discrimination against "qualified individuals with disabilities." A qualified individual with a disability is an individual with a disability, who meets the skills, experience, education, and other job-related requirements of a position held or desired, and who, with or without reasonable accommodation, can perform the essential functions of a job.

The attached form must be completed by the employee, the supervisor, and the attending physician and **returned within 10 working days to Human Resources**. <u>After all documents are submitted, an interactive meeting will be scheduled with the employee, employee's supervisor and Human Resources Officer</u>. All questions on this form must be answered completely. Incomplete or illegible answers may result in a delay of review. **Please be sure to keep a copy of this form and any attachments for your records.**

PART A: EMPLOYEE'S STATEMENT

You, the employee, must complete this section. Please make sure you sign and date it at the bottom after you complete this section.

PART B: SUPERVISOR'S STATEMENT

The supervisor must complete and sign this section.

PART C: ATTENDING PHYSICIAN'S STATEMENT

You must complete and sign the top portion of this section. The physician who is *primarily* responsible for your care must complete the bottom portion of this section. Please ensure that your physician personally signs and dates this statement. Please attach any additional information that you feel will assist us in evaluating this request. All medical records obtained during the intake are confidential.

INTAKE APPLICATION FOR INTERACTIVE MEETING PROCESS

PART A: EMPLOYEE'S STATEMENT

Name ______________________________ **Employee ID** ____________________
Site ________________________________ **Position** ____________________________
Home Phone Number _______________ **Work Phone Number** _______________

What is the condition that makes you believe that you need an accommodation?

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What is the expected duration of this condition?

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____
____

How does this condition affect your ability to perform the essential functions of your job?

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____

What can the District do to help you perform your job duties?

____
____
____

____ ________________________
Signature **Date**

San Diego Unified
SCHOOL DISTRICT

INTAKE APPLICATION FOR INTERACTIVE MEETING PROCESS

PART B: SUPERVISOR'S STATEMENT

Employee's Name: ____________________________ EMPLID#: #__ __ __ __ __ __

Site/Department Name: ____________________________ Cost Center #__ __ __ __

Have you reviewed the Employee's Statement of this Intake Application?

_____ Yes ______ No

List any recommendations you have to assist the employee in performing the essential functions of his/her job. These recommendations will be discussed and reviewed at the interactive meeting.

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Additional Comments

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______________________________________ ______________________

Signature **Date**

______________________________________ ______________________

Title **Phone Number**

PART C: AMERICANS WITH DISABILITIES ATTENDING PHYSICIAN STATEMENT

NAME OF PATIENT: ____
PATIENT ADDRESS AND PHONE: ______________________________________

I, ______________________________, hereby authorize my treating physician/psychologist to release information requested in this document to SDUSD for the purpose of facilitating my request for reasonable accommodation.

Signature ____ **Date** ____________________

IMPAIRMENT:

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WHAT MAJOR LIFE ACTIVITY DOES THIS IMPAIRMENT LIMIT?
(Examples: hearing, seeing, walking, lifting, learning, performing manual tasks, etc…)

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Restrictions as they relate to the performance of the essential functions of the job (Refer to Position Description on district website: www.sandi.net and click on Employment link and detailed Job Analyses if applicable.)

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Recommended accommodations as they relate to the performance of the essential functions of the job (Refer to Position Description on district website: www.sandi.net and click on Employment link and detailed Job Analyses if applicable.)

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____ ____________________________
Print or Type Name **Medical Specialty**

____
Name of Organization

____ ____________________________
Phone Number **Fax Number**

____ ____________________________
Signature **Date**

Please attach additional sheets supporting the diagnosis, as needed.