

**School District of Philadelphia**

**Application for Reasonable Accommodation**

**Under The Americans with Disabilities Act or Applicable State or Local Law**

*Please complete and return the forms via Email to: Employee Relations at [employeerelations@philasd.org](mailto:employeerelations@philasd.org) or via First class mail to Office of Talent, 440 North Broad Street, Suite 202, Philadelphia, PA 19130 or by fax to 215.400.4601*

Employee: \_\_\_\_\_  
(Print Name)

Position: \_\_\_\_\_

Building/Location: \_\_\_\_\_

Date of Request: \_\_\_\_\_

1. Please describe the reasonable accommodation that you are requesting.

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2. For how long do you need the reasonable accommodation?

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3. If not obvious, please describe the nature of your disability and include or attach any information that will help us understand the nature of your disability and the limits it places upon (a) your ability to perform your current job and/or your ability to enjoy the benefits/privileges of the workplace.

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4. List and describe all of the functions of your job that you are unable to perform or need help performing *because of your disability*. If you are requesting an accommodation to allow you to enjoy certain benefits/privileges of the workplace, please describe the benefits/privileges that you are unable to enjoy *because of your disability*. You should supply as much specific detail as possible.

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5. Please describe how the requested accommodation will help you perform the functions of your job and/or allow you to enjoy the benefits/privileges of the workplace.

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If necessary, I authorize my health care provider/insurer to release information necessary to evaluate my accommodation request: (Note: Your request may be denied if the School District of Philadelphia does not have sufficient medical information to consider your request.)

Yes

No

Name of Health Care Provider: \_\_\_\_\_

Phone Number of Health Care Provider: \_\_\_\_\_

Fax Number of Health Care Provider: \_\_\_\_\_

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

\_\_\_\_\_  
Date