San Diego Unified
SCHOOL DISTRICT

INSTRUCTIONS FOR COMPLETING THE
AMERICANS WITH DISABILITIES INTAKE APPLICATION
FOR INTERACTIVE MEETING PROCESS
Human Resource Services Division

The purpose of the ADA Process is to engage in an interactive dialogue focused on possible accommodations that would enable an employee to perform their usual and customary duties with or without accommodation. If you wish to engage in this process, complete Part A and Part C as outlined below. If you believe you are unable to work, please explore the leave options that might be available to you.

STEP I: Collection of documentation

PART A: EMPLOYEE'S STATEMENT

1. The employee must complete Part A: Employee Statement. You can save a copy of this form by selecting the option to email it to yourself when you complete it. 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.*

Click here to complete the online form: Part A: Employee's Statement

PART B: SUPERVISOR'S STATEMENT

2. The Human Resource Services Division will send this form to the employee's supervisor to be completed.

PART C: ATTENDING PHYSICIAN'S STATEMENT

You must complete and sign the top portion of this Part C form before providing it to your physician. The physician who is *primarily* responsible for your care of the condition or conditions you are requesting accommodation 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.

3. Once you obtain the physician's statement, please upload Part C to this secure folder: https://driveuploader.com/upload/xxEFvNXLJV/. All medical records obtained during this process are confidential.

The attached form must be completed by the employee, the supervisor, and the attending physician and **returned within 10 working days to Human Resources**. If you do not return this packet to us in the next 10 working days, we will assume that you've declined to participate at this time. If you need more time to complete the paperwork, please contact Rhonda Archard at rarchard@sandi.net. After all documents are submitted, an interactive meeting will be scheduled with the employee, employee's supervisor and Human Resources Officer. All questions on thisf orm 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.**

California Department of Fair Employment and Housing Non- Discrimination in Employment Employee Notification *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.* AR 4030 outlines the complaint and investigative process for claims of discrimination. Complaints may be filed online using this form.

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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:

_____

_____

_____

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

_____

_____

_____

Restrictions as they relate to the performance of the essential functions of the job (Refer to Position Descriptions on district website).

_____

_____

_____

Recommended accommodations as they relate to the performance of the essential functions of the job. (Refer to Position Descriptions on district website).

_____

_____

_____

_____ _____
Print or Type Name **Medical Specialty**

_____
Name of Organization

_____ _____
Phone Number **Fax Number**

_____ _____
Signature **Date**

Please attach additional sheets supporting the diagnosis, as needed.

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