APPENDIX D

MIAMI-DADE COUNTY PUBLIC SCHOOLS
AMERICANS WITH DISABILITIES ACT (ADA) DISTRICT CONSULTATIVE COMMITTEE

EMPLOYEE SELF-REFERRAL FORM
REQUEST FOR REASONABLE ACCOMMODATIONS UNDER THE ADA

Instructions: *When this questionnaire is fully completed, sign, date, and return it to Madeleine Rodriguez, Chairperson, ADA District Consultative Committee, School Mail Code 9322. Please print legibly or type the information requested. If you need additional space, please attach separate sheets of paper identifying your response to the question by number.*

Name:_____ Employee Number:_____

Home Address:_____ Home Telephone:_____

Immediate Supervisor's Name:_____

Worksite Name:_____ Mail Code: _____

Your Job Title:_____ Worksite Telephone:_____

1. Do you currently possess the experience, training, certification or licensure for the job position you occupy? Yes __ No __ Please specify _____
2. Do you have a physical and/or mental condition/impairment? Yes __ No__
3. What type of condition(s)/impairment(s) are you requesting accommodations for (Diagnosis)?

   _____
   _____
   _____

4. Who made the diagnosis (provide name(s), address(es) and telephone number(s) of the health care provider(s) who made the diagnosis)?

   _____
   _____
   _____

Please attach a medical statement or other current documentation from your current health care provider regarding the specific conditions/impairments listed in item three. Current documentation must be dated within the past six months from the date this questionnaire is submitted. Additionally, the documentation must indicate the specific doctor(s) treating the conditions listed above.

5. On what date(s) were you first diagnosed with the condition(s)/impairment(s)?

   Date(s): _____

6. On what date(s) did you start treatment for the condition(s)/impairment(s)?

   Date(s):_____

7. Do you experience any limitations in your personal life (outside of work) as a direct result of the condition or impairment? __ Yes __ No If so, please state whether any of the following activities are limited:

Walking:	Yes __ No__	Seeing:	Yes __ No__	Hearing:	Yes __ No__
Speaking:	Yes __ No__	Breathing:	Yes __ No__	Learning:	Yes __ No__
Sitting:	Yes __ No__	Standing:	Yes __ No__	Lifting:	Yes __ No__
Thinking:	Yes __ No__	Concentrating:	Yes __ No__		
Caring for oneself:	Yes __ No__	Performing manual tasks:	Yes __ No__		

8. If you answer *"yes"* to any of the above, please explain *in detail* how the condition/impairment limits or restricts those activities:

   _____
   _____
   _____

9. Does any medical treatment, use of prosthetic devices, or taking of medications reduce your symptoms or limitations? If so, list all treatments, prosthetic devices, and/or medications below. If you are not taking any corrective measures, explain why.

   _____
   _____
   _____

10. Are you consistently following your treatment plan, as specified by your doctor, and if not, why not?

    _____
    _____
    _____

11. If you suffer side effects from the medications or treatments, please list them below:

_____

_____

_____

12. Do you experience any limitations in your work (specific job tasks) as a direct result of the condition or impairment? If so, list those limitations.

_____

_____

_____

13. Can you perform the essential functions of your job with or without a reasonable accommodation? Please explain your response.

_____

_____

_____

14. What reasonable accommodations would allow you to perform the functions of your job? (List all possible accommodations.)

_____

_____

_____

15. Is the reasonable accommodation needed *because* of the impairment? Yes ____ No ____

_____

_____

_____

16. If you ***cannot*** perform a function of your job with reasonable accommodations, please list those job functions below:

_____

_____

_____

17. Does your impairment/condition prevent you from working in any type/kind of job? If so, list all jobs which you are prevented from performing.

_____

_____

_____

18. Please list the name(s), address(es), telephone number(s) and specialties of all health care providers who will be submitting a completed “Medical Information Form” attached to this questionnaire and execute an “Authorization for Release of Medical/Psychological Information” for each health care providers listed below:

NAME OF PROVIDER SPECIALTY TELEPHONE NUMBER

_____

_____

_____

_____

_____

_____

Signature:_____ Date: _____