Town of Leverett -- ADA Reasonable Accommodation Request Form

Employees and Job Applicants (check one): □ Employee □ Applicant

Name: _____ Department: _____

Position: _____ Phone(s): _____

Date of Hire: _____ Anticipated Start Date: _____

Supervisor: _____ Phone: _____

Relevant Functional limitation(s):

_____

_____

_____

Requested accommodation(s):

_____

_____

_____

Why is the requested accommodation needed?

_____

_____

Has this accommodation been used by this individual in the past? □ Yes □ No

If "Yes," please explain: _____

_____

If "No," what accommodation enabled this individual to perform essential job functions?

_____

Has the individual ever requested an accommodation while employed by the Town of Leverett? □ Yes □ No If "Yes," what was the accommodation and how effective was it?

_____

_____

Other comments: _____

_____

Signature: _____ Date: _____

Office Use Only: Date of receipt of request: _____ Response date: _____

Requested accommodation granted: □ Yes □ No

Alternative accommodation: □ Yes □ No Explanation: _____

_____

_____

Expected accommodation date: _____ Actual accommodation date: _____

Town of Leverett Medical Provider Authorization to Release Documentation of Disability

To be completed by employee/job applicant: check one: □ Employee □ Applicant

I (print employee/applicant name) _____
residing at (print address) _____
hereby authorize (print name of medical provider) _____
of (print medical provider address) _____
to speak to and release any and all information regarding my case and medical file to the Leverett ADA Coordinator and Selectboard, relating to my request for reasonable accommodation(s).

Employee/applicant signature: _____ Date: _____

To be completed by Medical Provider:

You are being asked to provide documentation of disability for your patient/client. Please describe your specialty/qualifications to make a diagnosis: _____
_____

To Medical Provider: The above individual has stated that he/she has a disability, defined by the Americans with Disabilities Act as (1) a physical or mental impairment which substantially limits one or more major life activities, or (2) a record of such an impairment, or (3) is regarded as having such an impairment. “Major life activities” means functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one’s self, performing manual tasks, reproduction, and working. In your professional opinion does your patient/client have a disability and, if so, please describe the nature of the disability including the relevant diagnosis: _____
_____

Please describe any relevant functional limitations, including (important) which major life activities are substantially limited: _____
_____

Please describe any recommended accommodation(s), and how these will enable your patient/client to (a) perform the essential functions of his/her job, or (b) complete the job application process: _____
_____
_____

Additional Comments: _____
_____

Please return this completed form to: Marjorie McGinnis, ADA Coordinator, Town of Leverett, 9 Montague Road, PO Box 300, Leverett, MA 01054; fax 413-548-9699; email townadministrator@leverett.ma.us

The Town of Leverett does not discriminate on the basis of disability. The Town will provide auxiliary aids and services, written materials in alternate formats, and reasonable modifications in policies and procedures to persons with disabilities upon request.