School Board of Brevard County
ADA - Workplace Accommodation Request Form

Return this completed form along with your doctor's note to Linda Burpee in the Employee Benefits and Risk Management Office. Phone (321) 633-1000 ext. 620

Employee:_____Date of Request:_____/_____/_____

Title:_____Location:_____

What is your condition/limitation and how does it affect your ability to perform the essential functions of your job?

_____

_____

_____

Workplace accommodation(s) requested: _____

_____

_____

_____

Please list your physician's names and telephone numbers who have information concerning your disability and your need for reasonable accommodation:

_____

_____

_____

I hereby authorize the above listed health care providers and any others who have treated me to release to the School Board of Brevard County, any information concerning the disability disclosed herein and provide any opinions to them concerning my ability to perform essential job-related functions with or without reasonable accommodations. I also release the above listed physicians to speak with the school district personnel directly regarding my condition and limitations. I certify that the foregoing statements are complete, accurate, and true to the best of my knowledge, and I understand that the School Board of Brevard County may require me to undergo testing or evaluation by medical personnel retained by the School Board for the purpose of establishing the existence and extent of my disability to perform essential job-related functions with or without reasonable accommodations.

Employee's Signature_____Date:_____

*** This Section Completed by the District Office ***

___Approved___Not Approved___Approved with modifications: _____

Signature:_____Date:_____/_____/_____

Staff Notified on:_____/_____/_____