# Disability Accommodation Request Form

Prince William County Public Schools

Department of Human Resources

P.O Box 389

Manassas, VA 20108

Phone: 703.791.8568

Email: [ADA@pwcs.com](mailto:ADA@pwcs.com)

**Please submit the completed form to** [**ADA@pwcs.edu**](mailto:ADA@pwcs.edu)**.**

## To Be Completed by Employee

**Employee Name**:

**Employee ID Number**:

**Position**:

**Work Location**:

**Work Phone Number**:

**Home Phone Number**:

**Supervisor Name**:

**Supervisor Number**:

### **1. Describe any job functions that are you having difficulty performing due to a disability.**

### **2. Describe the functional limitations caused by your disability for which you are requesting an accommodation.**

### **3. Describe any accommodations that you believe would minimize or eliminate the functional limitations listed above.**

**Employee Signature**:

**Date**:

## To Be Completed by Employee’s Physician

### **1. Health Care Provider’s Name and Business Address/Telephone Number**

### **2. Does this employee have a physical or mental impairment? (If yes, please state the type of impairment.)**

### **3. Please describe the nature of the employee’s medical condition.**

### **4. When was the employee diagnosed with this condition? What is the expected duration?**

### **5. When was this employee last seen?**

### **6. List each major life activity limited by the impairment and describe how the employee is restricted due to the condition.**

### **7. If applicable, list the work functions that the employee is unable to perform based on this condition.**

### **8. Based on the limitations listed above, describe any reasonable accommodations that would assist the employee in performing his or her job duties.**

**Physician Signature**:

**Date**: