



# MEDICAL PROVIDER'S STATEMENT VERIFICATION OF NEED FOR ACCOMMODATION



**To the provider:** Portland Public Schools continually strives to meet the needs of its employees. We are requesting your input regarding this employee to help us determine whether a reasonable accommodation is needed to enable the employee to perform the essential functions of his/her job.

Name of Employee: \_\_\_\_\_

Does this person have a physical or mental impairment that substantially limits one or more major life activity (i.e., working, walking, talking, seeing, hearing, caring for oneself)?  Yes  No

If yes, please describe the disability and medical diagnosis.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long is this disability anticipated to last? \_\_\_\_\_

Does this disability, in your opinion, limit this person's ability to perform the essential functions of his/her job? (See attached job description.)  Yes  No

If yes, how? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Based on the job requirements listed on the attached job description, are there any accommodations you might suggest that would enable this person to perform the essential functions of his/her job?

Yes  No

If yes, what do you suggest? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider's Name  
**(Please Print):** \_\_\_\_\_ Phone: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to: Portland Public Schools Fax: 503-916-3107  
Human Resources  
**Attn: Legal Counsel**  
PO Box 3107  
Portland, OR 97208-3107