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: _____

Fax: 503-916-3107

Please return this form to:

Portland Public Schools
Human Resources
PO Box 3107
Portland, OR 97208-3107