

**POLICY TITLE: Physician Request for Reasonable Accommodations Form**

**POLICY NO: 401F4  
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**Wendell School District #232  
PHYSICIAN REQUEST FOR REASONABLE ACCOMMODATIONS**

Please complete the form and return to : Wendell School District Attn: Superintendent P.O. Box 300  
Wendell, ID 83355

Employee/Applicant Name: \_\_\_\_\_

Position/Title: \_\_\_\_\_ School/Office: \_\_\_\_\_

A. Identify the employee/applicant's impairment(s) and indicate how the impairment affects his/her ability to participate in the job application process or perform his/her job duties (please be as specific as possible):

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

B. State the accommodation(s) necessary to enable the employee/applicant to participate in the job application process or to perform the essential functions of his/her job, and explain how the suggested accommodation(s) will assist the employee/applicant (the position and essential job functions are attached):

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

Name of Healthcare Provider Providing Information: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_