

**CONFIDENTIAL**

**CHICAGO PUBLIC SCHOOLS  
AMERICANS WITH DISABILITIES ACT (ADA)  
REQUEST FOR REASONABLE ACCOMMODATION**

**HEALTH CARE PROVIDER CERTIFICATION**

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

Health Care Provider:

Your patient has requested that the Chicago Public Schools (CPS) provide a reasonable accommodation(s) so that he/she can perform the essential functions of the job he/she has, or is seeking. It is necessary that you provide the following information within thirty (30) days from the date at the top of this form so that CPS can determine whether this person is an "Individual with a Disability" as defined by the Americans with Disabilities Act (ADA).

Patient's Name:

\_\_\_\_\_  
Last                                      First                                      Middle Initial

\_\_\_\_\_  
Employee Identification Number (If none provide employee SSN)

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Length of time you have provided treatment to patient:

\_\_\_\_\_

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**Please attach additional sheets as necessary to respond to the following.**

**1. Please detail patient's diagnosis:**

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**2. Provide specific ICD-9-CM/DRG medical codes:**

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**3. What are the patient's physical and/or mental impairments?**

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**4. What is patient's prognosis as to each impairment and/or condition?**

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**5. Identify all major life activities, i.e., walking, talking, hearing, speaking, ability to care for self, etc., that are affected or limited by the patient's medical condition or impairment listed in paragraph 4:**

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**6. How does the patient's medical condition or impairment limit his/her ability to perform his/her job functions? Please describe in detail.**

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**7. Are the medical conditions or impairments that you describe in paragraph 6 permanent? If not, what is the projected duration of the patient's limitations or impairments that will interfere with his/her ability to perform his/her job functions?**

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**8. Provide names, telephone numbers and/or addresses of any referrals you provided to the patient.**

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I, the undersigned health care provider, certify that the information provided concerning \_\_\_\_\_, the above-named patient, is complete and accurate to the best of my knowledge. In signing this form, I agree to answer, in a timely manner, any questions the CPS may have about the basis of the statements made on this form. I understand that my cooperation is necessary for the CPS to make an accurate decision on my patient's request for a reasonable accommodation under the Americans with Disabilities Act.

\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Address

\_\_\_\_\_  
City / State / Zip Code

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

**Please return this form by mail and/or by facsimile to:**

**ATT: Ms. Michael Rowder, ADA Administrator  
Chicago Public Schools  
Equal Opportunity Compliance Office ("EOCO")  
125 S. Clark Street, 11<sup>th</sup> Floor  
Chicago, IL 60603  
FAX: 773/553-1091 Phone - Voice: 773/553-2698 TTY: 773/553-2699**