

# Americans with Disabilities Act General Information

School District of Osceola County  
817 Bill Beck Boulevard Kissimmee Florida 34744



## INTRODUCTION

The **Americans with Disabilities Act of 1990 (ADA)** is a law that was enacted by the U.S. Congress in 1990.

The ADA prohibits discrimination in all employment practices, including job application procedures, hiring, firing, advancement, compensation, training, and other terms, conditions, and privileges of employment. It applies to recruitment, advertising, tenure, layoff, leave, fringe benefits, and all other employment-related activities.

An individual with a disability is an employee or applicant who:

- ◇ has a physical or mental impairment that substantially limits one or more major life activities;
- ◇ has a record of such an impairment; or
- ◇ is regarded as having such impairment.

A qualified employee or applicant with a disability is an individual who:

- ◇ meets legitimate skill, experience, education, or other requirements of an employment position and who can perform the essential functions of the position with or without reasonable accommodation.

Reasonable accommodation may include, but is not limited to:

- ◇ making existing facilities used by employees readily accessible to and usable by persons with disabilities.
- ◇ job restructuring, modifying work schedules, reassignment to a vacant position for which the individual is qualified;
- ◇ acquiring or modifying equipment or devices, adjusting modifying examinations, training materials, or policies, and providing qualified readers or interpreters.

However, there is no obligation by the employer to:

- ◇ Find a position for an applicant who is not qualified for the position sought nor lower quality or quantity standards

An employer is only required to make an accommodation when:

- ◇ a "known" disability of a qualified applicant or employee is received.

Accommodations must be made on an individual basis as the nature and extent of a disabling condition and the requirements of a job will vary in each case.

Employers are not required to make an accommodation:

- ◇ if it would not impose an "undue hardship" on the operation of the employer's business. Undue hardship is defined as an action requiring significant difficulty or expense when considered in light of factors such as an employer's size, financial resources and the nature and structure of its operation.
- ◇ which would lower quality or production standards.
- ◇ by providing personal use items such as glasses or hearing aids.

### Osceola School Board Policy 2.70:

No person shall, on the basis of race, color, religion, gender, age, marital status, disability, political or religious beliefs, national or ethnic origin, or genetic information, or sexual orientation be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity, or in any employment conditions or practices conducted by this School District, except as provided by law.

**School District of Osceola County  
Human Resources Department**

The School District of Osceola County, Florida  
817 Bill Beck Boulevard  
Kissimmee, FL 34744

Dr. Karyle Green  
Chief Human Resources Officer  
ADA Coordinator

Phone: 407-870-4800  
Fax: 407-870-4086  
www.osceola.k12.fl.us



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## ADA Information Sources

### Osceola District ADA Forms

Visit the Osceola County website at [www.osceola.k12.fl.us](http://www.osceola.k12.fl.us). Select the Employee Intranet. Once logged in click on *Departments*, then *Human Resources*, and then *Disability Accommodations*.

### ADA—Disability Rights Federal Division

For information and technical assistance about the Americans with Disabilities Act (ADA), contact the ADA Information Line at 800-514-0301 (voice) or 800-514-0383 (TTY). Visit the ADA website at: <http://www.ada.gov/>

ADA Specialists are available to provide ADA information and answers to technical questions on Monday, Tuesday, Wednesday, and Friday from 10:30 a.m. until 4:30 p.m. or on Thursday from 12:30 p.m. until 4:30 p.m. (Eastern Time).

## Application Processing Procedures

1. An employee/applicant requesting accommodation will submit the "ADA – Workplace Accommodation Request Form" and "Healthcare Provider Certification of Medical Impairment" forms to their immediate supervisor who will forward the application to the District ADA Coordinator.
2. The ADA Coordinator or designee will collaborate with the employee/applicant and immediate supervisor to evaluate and determine eligibility within the guidelines of ADA. If the ADA Coordinator determines that additional medical information is needed, the employee/applicant will be furnished with any forms/questionnaires necessary for the health care provider to complete.
3. The ADA Coordinator or designee will then coordinate with the necessary staff and employee/applicant to determine and implement the effective, reasonable accommodation and timeframe that will enable the employee/applicant to perform their essential job functions.
4. The ADA Coordinator will thereafter prepare a memo providing an accommodation plan for signature by the employee/applicant and supervisor granting the accommodation and providing a format for timely or periodic review. In the event the accommodation is denied, a statement explaining and detailing the Coordinator's determination that there was no effective, reasonable accommodation that would enable the employee/applicant to perform the essential functions of the position would be issued.

## Appeal Process

A reasonable accommodation under the ADA is an ongoing process. At any point in time the individual receiving the reasonable accommodation or having accommodation denied may request a re-evaluation of the request from the Superintendent, whose decision shall be final for the District. The employee retains all rights thereafter to file any review or complaint as allowed by and under the law.

## Confidentiality

All medical-related information shall be kept confidential and maintained separately from other personnel records, available only under limited conditions.

## Retention

All request for accommodation forms and supporting documentation that are submitted to the ADA Coordinator will be maintained in a confidential manner in accordance with applicable federal and state mandated retention schedules.

**Questions, complaints, requests for additional information or requests for accommodations regarding ADA may be forwarded to the Chief Human Resource Officer, who is the designated District ADA Coordinator: Dr. Karyle Green.**



**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**

***Human Resources and Employee Relations***

799 Bill Beck Boulevard • Kissimmee • Florida 34744-4492  
Phone: 407-870-4800 • Fax: 407-870-4086 • www.osceolaschools.net

**ADA - WORKPLACE ACCOMMODATION REQUEST FORM**

Complete this form and FAX to 407-870-4086 in Human Resources

**Employee's Name:** \_\_\_\_\_

**Employee's ID No. and Position:** \_\_\_\_\_

**Employee's Phone No.:** \_\_\_\_\_

What is your condition/limitation and how does it affect your ability to perform the essential functions of your job?

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

Workplace accommodation(s) requested: \_\_\_\_\_

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

Please list your physician's names and telephone numbers who have information concerning your disability and your need for reasonable accommodation: \_\_\_\_\_

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

I hereby authorize the above listed health care providers and any others who have treated me to release to The School District of Osceola County, FL any information concerning the disability disclosed herein and provide any opinions to them concerning my ability to perform essential job-related functions with or without reasonable accommodations. I also release the above listed physicians to speak with the school district personnel directly regarding my condition and limitations. I certify that the foregoing statements are complete, accurate, and true to the best of my knowledge, and I understand that The School District of Osceola County, FL may require me to undergo testing or evaluation by medical personnel retained by the Board for the purpose of establishing the existence and extent of my disability to perform essential job-related functions with or without reasonable accommodations.

Employee's Signature: \_\_\_\_\_

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

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**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**

**Karyle Green, Ed.D.**

**Chief Human Resources Officer**

799 Bill Beck Blvd.

Kissimmee, FL 34744

O: 407-870-4800 Ext. 65005      FAX: 407-870-4086

karyle.green@osceolaschools.net

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**  
**HEALTHCARE PROVIDER CERTIFICATION OF MEDICAL IMPAIRMENT**

**Employee Name and ID Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Telephone Number(s):** \_\_\_\_\_

**Work Location:** \_\_\_\_\_

**Current Job Title:** \_\_\_\_\_

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**Clinic's Name:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_

**Clinic's Address:** \_\_\_\_\_

**Clinic's Phone Number:** \_\_\_\_\_

**Clinic's Fax Number:** \_\_\_\_\_

Dear Health Care Provider,

We are responding to your patient's request for an ADA Workplace Accommodation under the American with Disabilities Act. Your assistance in this process will be beneficial in assisting our employee. Please review the attached job description and respond to the following questions.

Thank you for your assistance.



Karyle Green, Ed.D.

Chief Human Resources Officer

The School District of Osceola County, FL

**PLEASE RETURN VIA FAX TO 407-870-4086**

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FL  
HEALTHCARE PROVIDER CERTIFICATION OF MEDICAL IMPAIRMENT**

1. Identify each diagnosis to indicate whether chronic or acute; permanent or temporary; the severity; date of onset; and expected duration. Employee's Name: \_\_\_\_\_

| Diagnosis | Chronic or Acute | Permanent or Temporary | Severity (Mild, Moderate, Severe) | Date of Onset | Expected Duration |
|-----------|------------------|------------------------|-----------------------------------|---------------|-------------------|
|           |                  |                        |                                   |               |                   |
|           |                  |                        |                                   |               |                   |
|           |                  |                        |                                   |               |                   |
|           |                  |                        |                                   |               |                   |
|           |                  |                        |                                   |               |                   |

2. Does the employee's medical condition preclude or substantially limit the individual from performing any of the duties list on the enclosed job description. If so, identify which specific duties the employee is precluded from performing or substantially limited in his or her ability to perform due to medical necessity. For the purposes of this document and in accordance with guidance promulgated relative to the ADA, the definition of a substantial limitation means the employee would not be able to perform the task in a manner that would be comparable to that of the general population.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Is there a medical reason to believe that the employee will experience injury, harm, or aggravation of his or her medical condition by attempting to perform the duties that you have provided in your response to number 2 above? Is so, what is the degree of injury, harm or aggravation that should be expected and what is the likelihood it may occur? What is the time frame in which it is likely to occur?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Is the employee likely to recover sufficiently to perform the duties described in the attached job description? If so, what is the expected time frame for recovery? If not, what is the **medical reason** that would inhibit recovery?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

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