EMPLOYEE ADA
HEALTHCARE PROFESSIONAL AUTH0RIZATION

I. The employee has granted you permission to speak with HCPSS regarding their ADA request.

Employee:

Full Name:	E#:
Job Title:	Phone #:
Department/School:	Supervisor

Healthcare Provider:

Name:	Phone #:
Address 1:	Email:
Address 2:	Specialty:

II. PERMISSABLE ACTS. The Healthcare provider and/or staff may communicate with the Howard County Public School System (HCPSS) regarding the employee's request for ADA Accommodation.

III. TERM. The aforementioned permission shall be permitted for:

☐ - The duration of the requested accommodation.
☐ - **A Specific Date**. Select date _____.
☐ - **Until the Employee Cancels** in writing by signing below and submits the document to the Office of Employee and Labor Relations.

IV. DISCLOSURE. The Employee authorizes HCPSS to discuss information regarding the ADA request for accommodation with the Healthcare provider/and or office staff. The Employee agrees to hold HCPSS, its Board, directors, employees, agents, successors and assigns harmless from all legal, financial, and any other liability none of whom admit any liability to the undersigned, but all expressly denying liability, from any and all claims, demands, damages, actions, causes of action or suits of any kind or nature whatsoever, which have or may hereafter have, arising out of or in any way relating to any and all injuries and damages of any and every kind, to both person and property, and also any and all injuries and damages that may develop in the future, as a result of or in any way relating to the permissible acts herein.

Employee Signature:	Click or tap to enter a date.

☐ I wish to revoke this authorization:

Employee Signature:	Click or tap to enter a date.