Employee Request for Reasonable Accommodations Packet

University of Pittsburgh at Johnstown
Office of Health & Wellness Services
Disability Services

Phone: (814) 269-7119 Fax: (814) 269-7179
Address: 450 Schoolhouse Rd. Johnstown, PA 15904

UNIVERSITY OF PITTSBURGH AT JOHNSTOWN

Office of Health & Wellness Services
Disability Services
Student Union G-10

Phone: (814) 269-7119
Fax: (814) 269-7179

450 Schoolhouse Rd.
Johnstown, PA 15904

Health Care Provider Release Form

I, _____, hereby authorize you to complete the attached *Health Care Provider Verification Form* and disclose to the Pitt-Johnstown Executive Director of Health & Wellness Disability Services, and other Pitt-Johnstown representatives as necessary, any records and/or information relating **only to the condition(s)** for which I am requesting reasonable accommodations:

_____
(list the condition(s) for which you are requesting reasonable accommodations)

This information will be used for the purpose of evaluating my request for a reasonable accommodation under the Americans with Disabilities Act (ADA).

I understand that I have no obligation to disclose any information from my medical records, and all information disclosed pursuant to this Release shall be treated as confidential. I also understand that I may revoke this consent at any time by notifying you in writing of my decision, unless you have disclosed the information in reliance on my statement of consent.

I have read this form or have had it read and explained to me and I understand its contents.

Date: _____

Employee Signature: _____

Name/Address of Healthcare Provider: Phone Number:_____

_____

_____

_____

UNIVERSITY OF PITTSBURGH AT JOHNSTOWN

Office of Health & Wellness Services

Disability Services

Reasonable Accommodation Request Form – Employment

The purpose of this form is to assist the University in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially. Please return this completed form to Disability Services.

Department:

SECTION I: Employee: To be completed by employee requesting accommodation

Employee:	Telephone:
Address:	
Job Title:	Request Date:
Department Head/Supervisor	Telephone:
Address:	
Human Resources Officer/Representative:	Telephone:
Address:	

I give the University of Pittsburgh at Johnstown, Office of Health and Wellness: Disability Services, permission to explore coverage and reasonable accommodations on my behalf within the campus community as per the Americans with Disabilities Act. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements.

_____

Date Employee's signature

Please answer the following questions to assist us in understanding the basis and nature of your request for an accommodation (attach additional sheets if necessary).

A. Please describe as completely and specifically as possible the accommodation(s) you are requesting.

B. What are the limitations caused by your conditions(s) that you are currently experiencing? Please provide as much detail as you believe is relevant.

C. Regarding the limitations you noted above, what specific parts of your assigned responsibilities are difficult to perform because of your condition?

D. In order to facilitate our discussions to identify an effective accommodation, tell us what changes are needed in some component now part of your responsibilities, or the manner in which you now carry out your responsibilities to make it possible for you to continue to perform the essential functions of your position.

Forward a copy of this form to the Office of Health and Wellness Services, G 10 in the Student Union. If you have any questions, please contact Theresa Horner at 814-269-7119. *Please review the information regarding medical documentation on page 5 of this document.*

INFORMATION PERTAINING TO MEDICAL DOCUMENTATION:

In the context of assessing an accommodation request, medical documentation may be needed. Medical documentation is often needed to determine if the employee has a disability covered by the ADA and is entitled to an accommodation (i.e., has a permanent disability, as distinguished from temporary disability, that substantially limits one or more major life activities, affects the employee's ability to perform essential job functions, and is of sufficient severity) and if so, to help identify an effective accommodation.

Generally, in the context of an accommodation, medical inquiries related to an employee's disability and functional limitations are permissible and may include consultations with knowledgeable professional sources, such as doctors, occupational and physical therapists, rehabilitation specialists, and organizations with expertise in adaptations for specific disabilities. The Office of Disability Services in the University unit is charged with collection of medical documentation. In the event that medical documentation is required, the employee will be provided with the appropriate forms to submit to their medical provider. The employee has the responsibility to ensure that the medical provider follows through on requests for medical information.

UNIVERSITY OF PITTSBURGH AT JOHNSTOWN

Office of Health & Wellness Services
Disability Services

Health Care Provider Verification Form

Physical Health Related Disabilities Documentation

Request for Documentation of Physical/Mental Health Condition or Disability
(To be completed by a diagnosing Physician or Health/Mental Health Care Provider)

EMPLOYEE NAME: _____

The above is an employee of the University of Pittsburgh at Johnstown. The employee has requested a reasonable accommodation for a medical condition under the American's with Disabilities Act (ADA) and has identified you as the treating physician. The employee believes a reasonable accommodation relating to their condition is necessary to enable them to perform the essential functions of their job. To assist Pitt-Johnstown in evaluating this request for accommodation, please answer the following questions.

Please provide specific and detailed answers to these questions, using additional sheets where necessary. To assist you in completing this medical questionnaire, some questions contain narratives and definitions. Kindly review the narrative and/or definitions before answering the question. Pitt-Johnstown will use the information to evaluate the employee's request for accommodation in accordance with the ADA. The information you provide will be confidential and used to evaluate the employee's request for accommodation.

Please return the completed form to the employee.

1. Have you examined the employee for impairment relating to their request for reasonable accommodation?

Yes_____ No _____ Date of examination(s): _____

2. Does the employee have a "physical or mental impairment?"

Yes_____ No _____

In answering this question, the ADA defines a physical or mental impairment as (1) any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

3. If you answered "yes" to question 2, please identify the specific physical or mental impairment:

_____

_____

4. Does the above-identified impairment substantially limit a major life activity of the employee?

Yes_____ No_____

In answering this question the ADA defines the term substantially limits to mean (1) unable to perform a major life activity that the average person in the general population can perform: or (2) is restricted as to the condition, manner or duration under which the average person in the general population can perform that same major life activity.

The ADA also defines major life activities to mean functions such as caring for ones self performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

5. Please describe what major life activity(ies) are limited and describe how and to what extent the impairment substantially limits the activity(ies).

6. Is the impairment temporary or permanent? Temporary_____ Permanent_____

7. If the impairment is temporary, what is the expected duration of the impairment?

8. In what specific way(s) and to what extend does the impairment affect his/her ability to perform the essential functions of his/her job? (See attached job description and Essential Job Function statement).

9. What corrective devices (e.g. prosthesis, hearing aids, medication, therapies, etc.) have been prescribed or recommended for the above-described medical condition?

10. Do the recommended corrective devices or other measures affect, positively or negatively, the employee's ability to perform the essential functions of their job?

11. Which of the essential functions is he/she able to perform now?

12. Which of the essential job functions is he/she unable to perform?

13. Please provide any other medical information or documentation that you believe will assist in evaluating the nature, severity and duration of his/her impairment, the activity or activities the impairment limits and the extent to which the impairment limits his/her ability to perform the activity or activities.

14. Do you have any suggestions as to what types of accommodations should be considered?

15. Please describe your medical expertise as it relates to this case.

Thank you for taking the time to furnish this information on behalf of your patient. We will use the information you have provided to evaluate the employee's request for reasonable accommodation in accordance with the ADA. **The provider may also include a report that provides additionally related information if appropriate.**

Signature of Provider: _____ Date: _____

License # _____ State _____

(**Please print)**

Name/Title: _____

Address: _____

Phone: _____

Please return this form (and additional information, if included) to the employee, who will in turn provide the information to the Pitt Johnstown Health & Wellness Disability Services office.

NOTICE TO EMPLOYEE: return the completed form to:

Theresa Horner, *Executive Director*
Office of Health & Wellness
Student Union G-10
450 Schoolhouse Road
Johnstown, PA 15904