

Employee Request for Disability Related Accommodations

University of Rochester

Introduction

As an equal opportunity employer, the University is committed to taking affirmative action to employ and advance in employment qualified individuals with disabilities. This includes the commitment to make reasonable accommodations to the known physical or mental limitation of otherwise qualified individuals who seek employment at the University of Rochester.

If you are seeking disability related workplace accommodations, you can submit a request for accommodation by supplying the information requested on this and the following pages and submitting it to your Human Resources Business Partner or Liaison. If you aren't sure who that person is, you can see the list online at www.rochester.edu/working/hr/contact/contact_list.html or call 585.275.8747.

To request a disability related workplace accommodation, please follow these 3 steps.

1. Complete the following three items:
 - a. Employee Information Form (bottom of this page)
 - b. Health Care Provider Release Form (page 2) and
 - c. Reasonable Accommodation Request Form (page 3)
2. Ask your health care provider to fill out the attached form "Request for Documentation to Certify Disability" (pages 4 and 5).
3. Return the completed forms to your Human Resources Business Partner or Liaison.

Employee Information

Department: _____

Employee Name: _____

Address: _____

Job Title: _____

Supervisor: _____

HR Business Partner/Liaison: _____

Request Date: _____

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Health Care Provider Release Form

I _____, hereby authorize you to complete the attached Request for Documentation to Certify Disability, pages 4 and 5 of this packet, and to share with the Office of Human Resources, University of Rochester and other University of Rochester representatives, as necessary, any records and/or information relating **only** to the condition(s) for which I am requesting disability related accommodations:

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

This form will be used for the purpose of evaluating my request for a disability related reasonable accommodation pursuant to the Americans with Disabilities Act As Amended and other federal, state or local laws that protect individuals with disabilities from discrimination.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, I ask that you not provide any genetic information when in your responses to this request for medical information.

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 confidentially. I also understand that I may revoke this consent at any time by notifying you in writing of my decision. I have read this form or have had it read and explained to me and I understand its contents.

Date: _____

Employee Signature: _____

Name and Address of Health Care Provider:

Phone Number: _____

(name)

(address)

(address)

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Reasonable Accommodation Request Form

The purpose of this form is to assist the University in determining whether, or to what extent, a reasonable accommodation can be provided to allow you to perform the essential functions of your job safely and effectively.

We will confirm your medical condition with your provider, but ask that you 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. In what ways does your disability impact your ability to perform specific functions of your job (i.e., what specific functions or duties are you unable to perform without an accommodation due to your disability and why)?

- C. Please explain how you believe that the accommodations requested above will allow you to continue to perform the essential functions of your position.

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NOTE TO HR BPs and Liaisons: This form must be maintained and filed separately (under lock and key) from the employee's personnel file and be treated confidentially.

Request for Documentation to Certify 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 Rochester. The employee has requested a workplace accommodation due to a medical condition indicated to be disabling and has identified you as the treating physician. The employee believes that an accommodation is necessary to enable him/her to perform the essential functions of their job. Please answer the following questions, designed to assist the UR in evaluating this request and return the form to your patient, who will in turn submit to their HR representative. The information you provide will be confidential.

1. Have you examined the above mentioned employee in connection with the health condition(s) indicated on page 1 of this document? YES _____ NO _____
 - a. Is this person currently under your care for treatment of this health condition? YES _____ NO _____
2. If you answered "yes" to question 1, please identify the specific physical or mental impairment¹:

3. Is the impairment temporary or permanent? _____
4. If the impairment is temporary, what is the expected duration of the impairment?

¹ The Americans with Disabilities Act as Amended defines a physical impairment as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin and endocrine" and a mental impairment as "any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities." NYS Human Rights Law defines a disability as a physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques or a record of such an impairment or a condition regarded by others as such an impairment.

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5. Attached is a copy of the employee's Job Description (and, if available, Task Analysis form). In what specific way(s) and to what extent does the impairment affect his/her ability to perform the functions of his/her job?

6. Is there a particular accommodation which would enable the employee to perform the essential requirements of his/her job that you would recommend that we consider implementing?

Provider Signature: _____ Date: _____

License # _____ State: _____

Name/Title: _____

Address: _____

Phone: _____

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 and will follow up should we have additional questions. Please return this form to me by e-mail, fax or regular mail at the address listed below.

(HR Business Partner or Liaison Name)

(Address)

(e-mail)

(fax)