

Reasonable Accommodation Request Form

This form must be completed by an employee requesting reasonable accommodation(s) under the American with Disabilities Act of 1990 ("ADA"), Pennsylvania Human Relations Act, and Wilkes University policies. Completed forms are to be returned to the Human Resources Department.

1. NAME	2. DATE OF REQUEST
3. JOB/POSITION TITLE	4. DAYTIME TELEPHONE NO.
5. DEPARTMENT NAME/ADDRESS	6. EMAIL ADDRESS
7. SUPERVISOR'S NAME	8. SUPERVISOR'S TELEPHONE NO.

Please answer the following questions to assist the University in understanding the basis and nature of your request for an accommodation. The information you provide will be treated confidentially and will be handled on a need-to-know basis.

1. Identify the physical and/or mental impairment(s) for which you are requesting accommodation and the expected duration of the accommodation.
2. Explain how the impairment(s) listed above affect(s) your ability to perform the essential functions of your position or access employment benefits. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing.
3. Describe any type of accommodation which you believe will enable you to perform the function of the position or access employment benefits.
4. Describe how this accommodation will assist you in performing the function of the position or access to employment benefits.
5. If you have had any accommodation in the past for this same limitation, describe those accommodations and how effective they were.

6- For how long will the requested accommodation(s) be needed.

7. Do you have documentation to support your disability? YES _____ NO _____ If YES, please attach. [Documentation includes statements or other documentation from a physician or other professional identifying the disability and addressing what, if any, accommodations are necessary based upon your job duties. [See Medical Certification Form for additional information]. If you need a copy of a job description to provide to your medical professional, please contact Kathy Malcolm, HR Benefits Manager, kathrine.malcolm@wilkes.edu, 570-408-4644.

Acknowledgement

I understand that it is my responsibility to complete the attached Release of Medical Information Statement and to provide a Medical Certification Statement to the Human Resources Department for my request to be evaluated. I further understand that the Human Resources Department will evaluate and respond to me based upon the information that I provide.

SIGNATURE	DATE
RECEIVED BY HUMAN RESOURCES	DATE

Information or assistance regarding accommodation requests can be obtained by contacting the- Human Resources Department, kathrine.malcolm@wilkes.edu, 570-408-4644.

Release of Medical Information Statement

I, _____, understand that I am giving permission to Wilkes University Human Resources Department to contact the following individual(s) for purposes of requesting documentation/information regarding my disability including the diagnosis and limitations associated with that diagnosis. I understand that this permission will remain in effect from the day I sign this document until I revoke permission in writing or am no longer affiliated with Wilkes University.

Name _____

Address _____

Phone _____ E-mail _____

Name _____

Address _____

Phone _____ E-mail _____

I understand that communication with the above-named individual(s) will not include personal disclosures that do not pertain to my identified disability(ies). I understand that all medical information related to my request for accommodation is confidential and will be maintained in a secured location within the Human Resources Department separate and apart from my personnel file. I further understand that I will be required to provide the complete Medical Certification Form, attached, including the impact of functional limitations on my ability to perform the essential functions of my job.

SIGNATURE	DATE
RECEIVED BY HUMAN RESOURCES	DATE

Medical Certification Form

Note: The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act ("ADA").

To be completed by Employee

1. NAME	2. JOB POSITION/TITLE
3. SIGNATURE	4. DATE

To be completed by Health Care Provider

The employee listed, above, is an employee of Wilkes University. The employee has requested an accommodation for a disability and has identified you as their health care provider. The employee claims to have the following condition(s):

and that this condition(s) requires an accommodation to enable them to perform the essential functions of their job. To assist the University in evaluating this request for accommodation, please provide detailed answers to the following questions, using additional sheets where necessary. The information you provide will be considered confidential and used only to evaluate the employee's request for accommodation.

*Please return the completed form to Human Resources Department,
katherine.malcolm@wilkes.edu, Fax: 570-408-7879.*

Please Note: 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 law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

For reasonable accommodation under the ADA, an employee has a disability if the employee has an impairment that substantially limits one or more major life activities or a record of such an impairment.

1. Have you examined the employee for the above-stated condition? Yes _____ No _____
Date of examination(s): _____
2. Does the employee have a "physical or mental impairment?" Yes _____ No _____
3. If you answered "yes" to question 2, please identify the employee's specific physical or mental impairment (diagnosis):

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

Yes _____ No _____
5. If you answered "yes" to question 4, please describe what major life activity(ies) is substantially limited.

6. Please describe the manner and extent to which the impairment limits the above described major life activity(ies).

7. What is your prognosis for whether and in what manner the impairment will continue to limit the above-described major life activity(ies)?

8. What is the expected duration of the impairment?

9. How does the impairment affect the employee's ability to perform the essential functions of the employee's job? (See attached job description). Please be specific.

10. Please provide any additional medical information or documentation that you believe will assist the University in evaluating the impact of the employee's impairment; the activity or activities the impairment limits; and the extent to which the impairment limits the employee's ability to perform the activity or activities.

11. Please list any accommodation(s) you believe would enable the employee to perform the essential functions of the employee's job.

Thank you for completing this Medical Certification Form. The University will use the information you have provided to evaluate the employee's request for accommodation.

1. PHYSICIAN'S SIGNATURE	2. DATE
3. PHYSICIAN'S NAME	4. TELEPHONE NUMBER