Indiana University of Pennsylvania
Office of Human Resources

ADA Request for Accommodation Form

Date ____________________

Employee Name ____ Employee ID ________________

Title _______________________________Department _______________________________________

Work Location _______________________Supervisor ____

Work Schedule (days and hours)____

Please use the back of sheet if you need more room to answer any questions listed below.

1. Please describe the physical or mental impairment(s) that limit(s) your ability to do your job.

   a. What, if any, job function are you having difficulty performing?

   b. What, if any, employment benefit are you having difficulty accessing?

2. Describe the accommodations you are requesting. Be as specific as possible (i.e., if you are requesting a piece of equipment or device, please provide description, manufacturer, cost, where to order, etc.).

   a. If you are unsure of what accommodation is needed, do you have any suggestions?

   b. Have you had accommodations in the past for this same limitation? ___Yes ____ No

      If yes, what were they and how effective were they?

3. Describe how the requested accommodations will enable you to perform your job.

4. Please describe the expected duration of the requested accommodation:

   Permanent

   Until _____________

5. Please provide any additional information that might help evaluate your request.

Signature ____ Date _____________________________

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Release of Information for Employees

I, ______________________________, understand that I am giving permission to ______________________ of the Indiana University of Pennsylvania Office of Human Resources 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 the Office of the Chancellor of the Pennsylvania State System of Higher Education.

Name ____
Address____
____
Phone _________________________ E-mail ______________________________________

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 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 Office of Human Resources separate and apart from my personnel file. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of functional limitations on my ability to perform the essential functions of my job.

__________________________________ _______________
Signature Date

Indiana University of Pennsylvania
Office of Human Resources

ADA Request for Accommodation Form

ADA Medical Certification

Note: *The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA.*

To be completed by Employee

Employee Name ______________________________ Employee ID ______________

Title ______________________________ Department ______________________________

Employee Signature ______________________________ Date ______________

To be completed by Health Care Provider

Instructions: Attached are copies of the employee's job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and the environmental conditions associated with the job. **Please review both the attached job description and job analysis and prior to completing this form.**

Physician Name ______________________________

Specialization/Type of Practice ______________________________

Address ______________________________

Phone Number ______________________________

Questions to help determine whether an employee has a qualifying disability:

1. Does the employee have a mental or physical impairment? ____Yes ____ No

2. What is the impairment? ______________________________

3. Is the impairment long-term or permanent? ____Yes ____ No

4. If **not** permanent, how long will the impairment likely last? ______________________________

5. Is this condition considered a chronic condition which:

 a. Requires periodic visits for treatment by a health care provider? ____Yes ____ No

 b. Continues over an extended period of time? ____Yes ____ No

 c. May cause episodic rather than a continuing period of incapacity? ____Yes ____ No

6. Does the impairment mean that the employee is substantially limited in one or more major life activities? ____Yes ____ No

7. If yes, what major life activity(ies) is/are affected?

____caring for self
____lifting
____seeing
____reaching
____breathing
____working
____reproduction
____walking
____interacting w/others
____sleeping
____speaking
____thinking
____toileting
____other: ____
____hearing
____standing
____performing manual tasks
____concentrating
____learning
____sitting

Questions to help determine whether an accommodation is needed:

1. What limitation(s) in major life activities is/are interfering with this employee's job performance?

2. What job function(s) listed in the attached job description and job analysis is the employee having trouble performing because of the limitation(s)?

3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the job functions listed in the attached job analysis?

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Questions to help determine effective accommodation options:

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are those suggestions?

2. How would your suggestions improve the employee's performance?

Additional comments:

Health Care Provider Signature ____ Date _________________

All information provided is confidential and will be retained in the employee's medical file.

Return form to:

Indiana University of Pennsylvania
Office of Human Resources
G-8 Sutton Hall
1011 South Drive
Indiana, Pennsylvania 15705

Fax: 724-357-2685