Requesting a Reasonable Accommodation

In accordance with the Americans with Disabilities Act of 1990 ("ADA"), the Pennsylvania Human Relations Act, Section 504 of the Rehabilitation Act and Indiana University of Pennsylvania University (IUP) policies and practices, Indiana University of PA prohibits discrimination in employment against qualified individuals with disabilities on the basis of disability. It is the policy of IUP to provide reasonable accommodations in compliance with federal and state law.

A reasonable accommodation is a modification or adjustment to a job, the work environment, a policy, or the way things are usually done that enables a qualified individual with a disability to apply for employment, perform the essential functions of the employee's position, or enjoy the same benefits and privileges of employment that are available to similarly situated individuals without disabilities.

To request an accommodation and for further information along with the appropriate forms, an employee or applicant for employment may complete and submit the appropriate form by referring to the IUP HR website found here: Americans with Disabilities Act (ADA) - Office of Human Resources - IUP, or contact:

Anna Shively
The Office of Human Resources
1011 South Drive
358 Sutton Hall
Indiana, PA 15705
ashively@iup.edu
724-357-4875

Any request for accommodations must include information sufficient for the University to:

(1) confirm that the individual seeking an accommodation is a qualified individual with a disability;
(2) understand (a) the functional limitations with which the individual is faced as a result of the disability and (b) how those functional limitations impact the individual's ability to perform the essential functions of their job; and,
(3) in the event that a specific accommodation is proposed, understand how the proposed accommodation will enable the employee to perform the essential functions of their position, or, if a specific accommodation is not proposed, determine whether any reasonable accommodation exists. Any information, including medical records or correspondence from a medical provider, submitted to the University to support an accommodation request will be kept confidential and in a file separate from the employee's personnel file.

Once a request for an accommodation is received, the University will engage in an interactive process with the employee to understand the functional limitations caused by the employee's disability, the impact of those limitations on the employee's ability to perform the essential functions of their job, and whether the University is able to provide a reasonable accommodation that will enable the employee to perform the essential functions of their job.

In addition to discussions between the University and the employee, the interactive process may involve a review of available records, requests for additional information or documentation from the employee, consultation with the employee's medical provider, consultation with the employee's supervisor or other individuals with knowledge of the employee's position and the essential functions of the position, and consultation with other University personnel about the

University's ability to provide specific accommodations. The interactive process is intended to enable the University to determine whether the employee has a disability that interferes with the employee's ability to perform the essential functions of their job, and whether a reasonable accommodation can be provided to the employee to enable the employee to perform the essential functions of their job. If the University can provide a reasonable accommodation, without undue hardship, it shall do so. Reasonable accommodations are provided on an individualized basis, taking into account the limitations resulting from the individual employee's disability and how those limitations affect the employee's ability to perform their essential job functions.

If the employee believes they have been denied a reasonable accommodation to which the employee is entitled, the employee may appeal the decision to the Office of Social Equity, Elise Glenn, Chief Diversity & Inclusion Officer/Title IX Coordinator, eglenn@iup.edu within three (3) working days of the date of the decision. (Utilize a formal appeal process if used by your institution).

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 IUP policies. Completed forms are to be returned to the Office of Human Resources, Attn:

Anna Shively
Assistant Director of Human Resources
Employee ADA Coordinator
1011 South Drive
358 Sutton Hall
Indiana, PA 15705
ashively@iup.edu
724-357-4875

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, when this impairment began, and the expected duration of the impairment.

2. Explain how the impairment(s) listed above substantially limit(s) your major life activities, including but not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

3. 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 essential functions of your job, and how your disability impedes your ability to perform those functions.

4. Describe any type of reasonable accommodation which you believe will mitigate the barriers caused by your disability and enable you to perform the essential function(s) of the position or access employment benefits.

5. Describe how any prospective accommodation described above will assist you in performing the essential functions of your position or improve access to employment benefits.

6. If you have previously been provided any reasonable accommodation(s) by the university for the functional limitations identified in this request, please identify the individual who authorized the reasonable accommodation and identify the specific accommodation(s) and their effectiveness in enabling you to perform the essential functions of your job.

7. Please include with this request any documentation that evidences your disability, the resulting functional limitations, the essential functions of your position, and how any proposed accommodation will address the limitations caused by your disability and facilitate your ability to perform the essential functions of your job.] [See Medical Certification Form for additional information]. If you need a copy of a job description to provide to your medical professional, please contact the Office of Human Resources, human-resources@iup.edu.

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 Office of Human Resources for my request to be evaluated. I further understand that the Office of Human Resources 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:

Anna Shively
Office of Human Resources
Assistant Director of Human Resources
Employee ADA Coordinator

1011 South Drive
358 Sutton Hall
Indiana, PA 15705
ashively@iup.edu
724-357-4875

Release of Medical Information Statement

I, _____, understand that I am giving permission to 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 authorize the following individual(s) to disclose documentation/information regarding my disability, including the diagnosis and limitations associated with that diagnosis, for purposes of making a determination about my request for a reasonable accommodation. 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 Indiana University of Pennsylvania.

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 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 Office of Human Resources 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 an 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 Indiana University of Pennsylvania. The employee has requested an accommodation for a disability and has identified you as a health care provider who may have information about the employee's medical condition, the functional limitations they face as a result of the disability, and whether and how any potential accommodations would enable the employee 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

Anna Shively
Assistant Director of Human Resources
Employee ADA Coordinator
1011 South Drive
358 Sutton Hall
Indiana, PA 15705
ashively@iup.edu
724-357-4875

Within 15 days of being provided to the employee.

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 a physical or mental impairment that substantially limits one or more major life activities or a record of such an impairment.

1. Have you examined the employee for a condition that meets the above-stated criteria?
   Yes _____ No _____
   Date of examination(s): _____

2. Does the employee have a physical or mental impairment that results in functional limitations that prevent the employee from performing the essential functions of their job?
   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. Please indicate the approximate date when the employee's condition or impairment began to substantially limit their ability to perform a major life activity.
   _____
   _____

6. If you answered "yes" to question 3, please describe what major life activity(ies) is substantially limited.
   _____
   _____
   _____
   _____
   _____

7. Please describe **how** the impairment limits, and **the extent to which** the impairment limits, the above-described major life activity(ies).
   _____
   _____
   _____
   _____
   _____

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

_____
_____
_____
_____
_____

9. What is the expected duration of the impairment?

_____
_____
_____
_____
_____

10. Is there any treatment being provided that may limit or alleviate the impairment? If yes, please describe how the medication or other treatment limits or alleviates the impairment.

_____
_____
_____
_____
_____

11. 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(ies) the impairment limits; and the extent to which the impairment limits the employee's ability to perform the activity(ies).

_____
_____
_____
_____
_____

12. 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**.

_____
_____
_____
_____
_____

13. Please list all modifications or adjustments to the work environment, or to the manner or circumstances under which the employee's position is customarily performed, that you believe would enable the employee to perform the essential functions of the employee's job.

_____
_____
_____
_____
_____

14. Please describe any functional limitations or restrictions that affect the employee's ability to perform the essential functions of their position. Examples may include limitations on lifting, standing, sitting, walking, or exposure to certain environments.

_____
_____
_____
_____
_____

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

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