AUGUSTA UNIVERSITY

Office of Employee Relations
Accommodation Request IR#

Employee Information

Name:	**DOB:**	**Job Title:**
Email:	**Phone:**	**Supervisor:**

Employee Request for Accommodation

A ***Reasonable Accommodation*** is any change or adjustment to a job or work environment that permits an employee with a disability to perform the essential functions of a job, or to enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities provided it does not create an undue hardship to the employer.

Accommodation Example

- **Job restructuring**
- **Modifying work schedules**
- **Reassignment to vacant position**
- **Modifying/acquiring facilities or equipment**
- **Additional unpaid or flexible leave**
- **Accessible Parking**
- **Other**

1. What accommodation are you requesting?

2. Please provide a brief description of your physical and/or mental impairment(s) which limit or have an effect on your ability to perform your job duties.

3. What specific task or duties do you feel your impairment has an effect on your being able to accomplish?

4. Describe how the requested accommodation(s) will enable or assist you with performing the duties of the position.

Accommodation Acknowledgment

I, _____ give Augusta University permission to explore options for a reasonable accommodations under the Americans with Disabilities Act (ADA) on my behalf. This may include speaking to university personnel and/or my health care professionals. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I understand that it will be my responsibility to:

- **Provide documentation of my disability which may include completing and submitting the medical release and certification, in a timely manner to the ADA Coordinator in the Office of Employee Relation. I further understand that the ADA Coordinator will evaluate and respond to me based upon the information that is provided by myself or my physician.**
- **I also attest that the information provided by me is true and correct to the best of my knowledge.**

Medical Release Consent

I, _____, give my health care provider permission to release medical information as it relates to my physical or mental impairment to Augusta University's Office of Employee Relations

Employee Signature:	**Date:**

******* Signature on this page denotes consent to the Accommodation Acknowledgment and Medical Release Consent ******

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Heath Care Provider Medical Certification

Name:	DOB: 01/12/1996	Job Title:

As the employee's provider, medical information is needed that will assist with employees request for a reasonable accommodation

1.) Please list the physical or mental impairment(s) and how long each impairment will likely last.

Impairment(s) /Condition(s)	Length of Impairment
_____	_____
_____	_____
_____	_____

2.) Does the impairment/condition listed above have an effect on the employee's ability to perform the essential functions of the job? ☐ **Yes or** ☐ **No.** **If yes, please review and complete page 3**

3.) Is the employee substantially limited in any major life activities ☐ **Yes or** ☐ **No? If yes, please check the major life activities affected.**

☐ Bending	☐ Learning	☐ Seeing	☐ Walking
☐ Breathing	☐ Lifting	☐ Sitting	☐ Speaking
☐ Caring for self	☐ Performing manual tasks	☐ Sleeping	☐ Standing
☐ Concentrating	☐ Reaching	☐ Standing	☐ Thinking
☐ Hearing	☐ Reading	☐ Eating	☐ Working
☐ Interacting with others			☐ Other _____

Prognosis

4.) If prognosis is unknown at this time, please answer the following questions.

Prognosis is pending the following?	Doctors Name/Facility	
☐ Surgery Date:		Recovery time:
☐ Consultation Date:		Report Date / /
☐ Therapy Date:		Completion Date: / /
☐ Testing Date:		Report Date: / /
☐ Labs Date:		Report Date: / /

5.) Date of next appointment? ____/_____/_____

6.) How would providing the accommodation listed on page (1) enable or assist the employee with being able to return to work?

_____

7.) What is being done that will enable the employee's condition to improve or make it more likely for the employee to return to work and perform the essential functions of the position?

_____

_____

Physicians Name: _____ **Physicians Signature:** _____

Heath Care Provider's Essential Functions Questionnaire	
Employee's Name:	**Job Title:**
Accommodation Requested:	
As the Employees' Health Care Provider, your assistance is needed in order to determine if the requested accommodation would assist the employee with performing the essential job functions If you have any questions, you may contact the Office of Employment Equity at (706) 721-7285.	

Accommodation Questions		
Below is a list of Essential Job Functions which are the basic job duties that an employee MUST be able to perform with or without an accommodation	**Is employee able to perform function?**	**After reviewing the Essential Functions, please list restrictions?**
Essential Function #1	☐ Yes ☐ No Date able to perform? ___/____/_____	Date Restrictions Expire: __/___/_____
Essential Function #2	☐ Yes ☐ No. Date able to perform? ___/____/_____	Date Restrictions Expire: __/___/_____
Essential Function #3	☐ Yes ☐ No Date able to perform? ___/____/_____	Date Restrictions Expire: __/___/_____
Essential Function #4	☐Yes ☐No Date able to perform? ___/____/_____	Date Restrictions Expire: __/___/_____
Essential Function #5	☐Yes ☐No Date able to perform? ___/____/_____	Date Restrictions Expire: __/___/_____

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Below is a list of Essential Job Functions which are the basic job duties that an employee MUST be able to perform with or without an accommodation	Is employee able to perform function?	After reviewing the Essential Functions, please list restrictions?

Essential Function #(6)

- **(a) Check the boxes for the applicable physical factors of the position.**
- **(b) Write the number for the corresponding Essential Function (EF) for which that factor is related.**
- **(c) Notate the amount of pounds for related factor.**
- **(d) Provide percent of time the employee may spend performing this factor.**

(a)	(b) Corresponding Essen Function	(c) Physical Factor	(d) % of Time
☐		Lifting	
☐		Pushing/Pulling	
☐		Walking	
☐		Sitting	
☐		Standing	
☐		Reaching	
☐		Kneeling	
☐		Stooping	

Physician's Name: _____

_____ ____/____/_____
Physician's Signature: **Date**

_____
Facility Contact Information

If you have any questions, please contact the ADA Coordinator in the Augusta University's Office of Employee Relations at (706) 721-7285

Additional comments:

_____

_____

_____