1701 Lacey Street
Cape Girardeau, MO 63701
573.334.4822
800.800.5123
SEhealth.org

Employee's Request for Reasonable Accommodation

Employee's Name: _____ Employee Number: _____

Request Date: _____ Job Title: _____ Department:_____

To be eligible for a reasonable accommodation under the Americans with Disabilities Acts (ADA/ADAAA) and/or state counterparts, you must be qualified to perform the essential functions of your position with or without an accommodation, and have a qualifying disability that limits a major life function. If you would like to be considered for a reasonable accommodation, please complete this voluntary form as completely as possible.

Information that you submit will be kept confidential except that: (1) accommodations needed or restrictions on the work or duties will be reported to your supervisor/manager; (2) first aid and safety personnel may be informed, if necessary; and 3) any other individual or government agency deemed necessary to assess your need for accommodation and your ability perform the essential functions of your job may be informed.

Please submit the forms in its' entirety to dbyrd@sehealth.org. Forms that are not completed, will not be reviewed.

1. Please describe the nature of your limitations, what life activity(s) it substantially limits, and how this life activity(s) is substantially limited.

2. How do your medical limitations affect your ability to perform your job?

3. Type of accommodation you are requesting:

   - ❑ Making facilities readily accessible
   - ❑ Modification of equipment or devices
   - ❑ Acquisition of equipment or devices
   - ❑ Modification to an exam, training material or policy
   - ❑ Additional time off
   - ❑ Other (specify):

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4. Please describe in detail the accommodation you are requesting and the anticipated duration:

5. How will the requested accommodation be effective in allowing you to perform the essential functions of your job?

6. Additional comments:

Employee Signature:_____ Date:_____

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, 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.

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Under the Americans with Disabilities Act ("ADA") and state counterparts, an employee has a disability if s/he has a physical or mental impairment that substantially limits one or more major life activities or has a record of such impairment.

Please answer the following questions, so that the Hospital may appropriately evaluate the employee's accommodation request in accordance with the ADA and/or state law.

Completed forms need to be returned to the employee for submission.

Medical Provider Report for Accommodation

Date:_____ **DUE DATE:** _____

Employee Name:_____ Date of Birth:_____

Job Title: _____ ☐ Job description attached.

1. Does this individual have a physical or mental impairment? ☐ Yes ☐ No

   If yes, what is the impairment?

   Approximate date condition commenced?

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2. Does the impairment substantially limit one or more major life activities as compared to most people in the general population? ☐ Yes ☐ No
If yes, please list major life activity(s) affected and explain.

(***Major life activities*** *include but are not limited to: bending, breathing, caring for oneself, communicating, concentrating, eating, hearing, interacting with others, learning, lifting, performing manual tasks, reaching, reading, seeing, sitting, sleeping, speaking, standing, thinking and walking. Also includes* ***major bodily functions****: bladder, bowel, brain, cardiovascular, circulatory, digestive, endocrine, genitourinary, hemic, immune, lymphatic, musculoskeletal, neurological, normal cell growth, operation of an organ, reproductive, respiratory, special sense organs and skin.)*

3. Describe the nature, severity and anticipated duration of this impairment.

☐ Temporary (explain):

☐ Temporary but will take longer than normal to heal (explain):

- Anticipated healing period:

☐ Temporary with residual effects (explain):

☐ Chronic (explain):

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4. If applicable, please provide any information as to whether the dog was professionally trained or a certificate that the dog is a working animal and will not disrupt the workplace.

5. If applicable, is the individual taking medication for treatment that may impair his or her ability to perform the essential functions of the job? Will there be an adjustment period to this medication and if so how long?

6. Please review the enclosed job description. What functional limitations does this impairment place on this individual's ability to perform the essential functions of the job? Please provide as much detail as necessary to support these limitations, including whether the limitations will be temporary or permanent.

7. How do the functional limitations listed impact the individual's ability to perform the essential functions of the job?

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8. If there are functional limitations that impact the individual's ability to perform the essential functions of the job, are there accommodations that would enable this individual to continue performing any of the above limitations in which you described? ☐ Yes ☐ No

   If yes, please Identified proposed accommodations and the anticipated duration:

9. What was the date of the patient's last appointment? _____

10. What is the date of the patient's next appointment? _____

_____ _____
Signature of Health Care Provider Name of Health Care Provider (Please Print)

_____ _____
Type of Practice Address

_____ _____
Phone Number Date Completed

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