Oregon TECH
Human Resources

Reasonable Accommodation Request Form

The purpose of this form is to assist the university in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. *This form shall be filed separately from the employee's personnel file and be treated confidentially.*

EMPLOYEE INFORMATION				
Name:			**ID#:**	
Department:			**Job Title:**	
Employee Type:	❒ Classified	❒ Faculty	■ Unclassified Admin	☐ Student
Supervisor Name:				
Contact Information				
Personal Email:				
Mailing Address:				
Phone 1:				
Phone 2:				
Work Schedule				
Shift Hours:				
Days Off	☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su ☐ Rotating			

Please answer each of the following questions to assist us in understanding the basis and nature of your request for a reasonable accommodation (attach additional sheets if necessary).

1. What medical condition(s) currently limit your ability to do your job?[1]

2. Does your medical condition(s) affect a major life activity (MLA)? If so, explain which MLA are affected?

3. How long have you had your medical condition(s)? How long have you been treated for the condition(s)?

4. Please describe the accommodation(s) you request. Be as specific as possible.

[1] 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 GINA. 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.

5. What is the reason you need an accommodation(s)? What things are you unable to do without an accommodation? Be as specific as possible.

6. If you are requesting a type of equipment or a device, please describe the equipment/device. Do you know where the equipment can be obtained? What does it cost? Please provide this information if applicable.

7. Is there any other information that would help us evaluate your request?

8. Do you think you can perform the essential functions of your job with or without reasonable accommodation?

If you have a recent statement from your doctor stating your diagnosis, prognosis, any restrictions you may have with respect to your employment, and/or the projected duration of those restrictions, please attach it to this form. With your written consent, Oregon Tech may request necessary medical information from your healthcare provider(s). ***Your request for reasonable accommodation cannot be processed without information from your healthcare provider.***

Attached is a medical release authorizing Oregon Tech to obtain medical information which is needed to evaluate a request for an accommodation under the Americans with Disabilities Act (ADA). I understand that all information obtained during this process will be maintained and used in accordance with ADA and all legal and regulatory requirements as they pertain to medical and genetic information confidentiality. I authorize my medical provider(s) to release such medical information, as indicated on the attached form, to Oregon Tech Human Resources. A photocopy of the attached medical release shall have the same force and effect as the original.

Healthcare Provider Contact Information	
Provider Name:	
Provider Address:	
Phone:	
Fax:	

Signature of Person Requesting Accommodation:

Employee Signature **Date**

Hand deliver, email, fax, or mail this form to: Human Resources

Hand Delivery Location	Mailing Address	Email/Fax/Phone
Snell Hall Room 107	3201 Campus Drive, Snell 107	sarah.henderson@oit.edu
Klamath Falls Campus	Klamath Falls, OR 97601	541-851-5200 (fax)/541-885-1028 (phone)

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Pursuant to my request for reasonable accommodation under the Americans with Disabilities Act, my employer, Oregon Tech, is conducting an inquiry to determine: (1) my eligibility for a reasonable accommodation; (2) if I am eligible, what reasonable accommodation, if any, would be appropriate; (3) the feasibility of the reasonable accommodation; (4) any possible alternative reasonable accommodations.

I authorize [provider name(s)] _____ to use and disclose a copy of the specific health information described below regarding [employee name] _____

date of birth _____ , consisting of: _____

_____

_____

_____

for the purpose of assisting my employer with my reasonable accommodation request.

To: Human Resources
Oregon Tech
3201 Campus Drive, Snell Hall Room 107
Klamath Falls, OR 97603
Fax: 541-851-5200
Phone: 541-885-1028

This authorization does not cover, and the information to be disclosed should not contain, genetic information. "**Genetic information**" includes: Information about an individual's genetic tests; Information about genetic tests of an individual's family members; Information about the manifestation of a disease or disorder in an individual's family members (family medical history); An individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and Genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

This authorization is limited to the following treatment(s):

_____

This authorization is limited to medical treatment during the following time period:

_____

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, and treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the healthcare services are solely for the purposes of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, send a written statement to:

Sarah Henderson
Human Resources
Oregon Tech
Snell Hall Room 107
3201 Campus Drive
Klamath Falls, OR 97603
Fax: 541-851-5200
Phone: 541-885-1028

SIGNATURE

I have read this authorization and I understand it.

Printed Name: _____ Expiration Date of Medical Release*: _____

Signature: _____ Today's Date: _____

* Unless otherwise indicated, this authorization expires one year from the date this release is signed.