OFFICE OF
EQUAL OPPORTUNITY

201 General Academic Building
Phone: 405-744-1156
Fax: 705-744-7872
Email: eeo@okstate.edu

Reasonable Accommodation Request Form

Guidance on Requests for Disabilities Accommodation in Faculty and Staff Employment

Section 1: Initial Request

FOR SUPERVISORS:

All requests for employment accommodation(s) based on disability should be filed with the Office of Equal Opportunity **ONLY**. **DO NOT** provide a copy of this completed document to a supervisor or member of the department. If a faculty, staff, student employee, or applicant seeks information about reasonable accommodation(s) in writing or verbally, please take the following steps:

1. The department will refer the employee or applicant to the Office of Equal Opportunity via phone at 405-744-1156 or by email at eeo@okstate.edu.
2. An ADA packet will be sent to the individual to complete. The Office of Equal Opportunity will review the request and completed ADA packet to begin the interactive process.
3. The individual requesting the reasonable accommodation(s) and supervisor will be notified whether a recommendation is made or not made to implement a reasonable accommodation(s).

Section 2: Interactive Process

FOR EMPLOYEES:

The Interactive Process is intended to provide departments and employees/applicants the opportunity to discuss and cooperatively determine the most appropriate and reasonable accommodation(s). Departmental representatives must communicate directly with the individual in good faith and in a timely manner. It is important that all efforts are made to ensure the process is not delayed or obstructed. The Office of Equal Opportunity will assist in the interactive process and may include the assistance of Human Resources Consulting Services, and other subject matter experts. Keep in mind, this process is in response to a request for reasonable accommodation(s). If an employee/applicant fails to participate in

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the process by not providing the required documentation, the interactive process will pause until the documentation is received by the Office of Equal Opportunity.

All medical and related documentation and discussion included in the ADA interactive process is kept on a secure server accessible **ONLY** by The Office of Equal Opportunity for privacy purposes. Departments are required to keep all documentation pertaining to requests for accommodation in accordance with prevailing record retention requirements of seven years.

Please submit this completed form to:

Human Resources, Office of Equal Opportunity

201 General Academic Building

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Employment Accommodation Request Form: For Employee/Applicant Use Only

Employee Information

Employee Name:	**Employee CWID:**
Employee Phone:	**Employee Email Address:**

Department and Workplace Location:	**Supervisor:**
Workplace Phone:	**Supervisor Phone:**

Accommodation Request Details: Attach additional sheets if needed.

1. Describe the impairment for the basis of the request and what life activity your impairment limits (e.g. caring for oneself, performing manual tasks, walking, etc.).

2. Detail essential functions of your job you cannot perform and how your disability impairs your ability in each instance.

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3. Describe the reasonable accommodation(s) (actions, changes, equipment, or modifications) you are requesting to enable you to perform the essential functions of your job and how these will enable you to meet the essential function.

4. Explain how the reasonable accommodation(s) you are requesting will enable you to perform the essential functions of your job. Be specific.

5. If no medical documentation exists, please why.

6. This condition is: ☐ Temporary ☐ Permanent

   ☐ Expected to last until (date)

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Please read the following carefully, then sign and date.

I have a disability I believe has, or may have, an adverse effect on performing my job duties. In order to minimize or eliminate the effect of the disability on my job requirements, I am voluntarily requesting OSU review my situation for the purpose of considering reasonable accommodation(s). I understand submitting this form is an initial step only. I understand OSU will not assume, based on my submission of this form, I am disabled or a change or accommodation in the workplace is required.

I understand OSU must be able to confirm the existence and the extent of the disability and how it may relate to the duties and responsibilities of the position involved. I understand this information is necessary so OSU can respond to this request, and this form and any attachments I have provided may be shared with the health care providers I have identified, as well as with other health care providers with whom OSU may consult in evaluating this request.

I also understand appropriate consideration of this request may require disclosure of information about my impairment to the Office of Equal Opportunity or who may have a need to know about the impairment to participate effectively in discussions about possible reasonable accommodations, and/or in implementing accommodations. I agree to provide any other information needed in order to respond to this request.

I hereby authorize the listed health care providers and any others who have treated me to release to OSU all medical records concerning the impairment disclosed herein as it may affect my ability to perform the essential duties of the job in question, and to provide any opinions to OSU concerning my ability to perform job-related functions with or without reasonable accommodation.

I certify I have read and reviewed the job description for my position, and/or have been informed of what the university considers the essential functions of this position. I further certify the foregoing statements are complete, accurate, and true to the best of my knowledge. I also understand OSU may require me to undergo further evaluation by medical personnel retained by the university for the purpose of establishing the existence and extent of my disability, and my ability to perform job-related functions with or without reasonable accommodations.

Signature

Date

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FOR PHYSICIAN USE ONLY

You may attach additional sheets to answer the following questions.

Section 1: Employee Impairment

Physician Name:	**Physician Phone:**
Physician Address:	**Office Email/Fax:**

Does the employee have a physical or mental impairment? ☐ Yes ☐ No

If yes, what is the impairment?

Is the impairment long-term or permanent? ☐ Yes ☐ No

If not permanent, how long will the impairment likely last?

Does the impairment substantially limit a major life activity? Please note, does not need to significantly or severely restrict to meet this standard. ☐ Yes ☐ No

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If yes, what major lift activity(s) is/are affected?

- ☐ Self-Care
- ☐ Walking
- ☐ Hearing
- ☐ Lifting
- ☐ Communicating
- ☐ Standing
- ☐ Seeing
- ☐ Sleeping
- ☐ Performing manual tasks
- ☐ Reaching
- ☐ Speaking
- ☐ Concentrating
- ☐ Breathing
- ☐ Thinking
- ☐ Learning
- ☐ Working
- ☐ Toileting
- ☐ Sitting
- ☐ Other (describe):

Section 2: Employee Limitations

What limitation(s) is/are interfering with job performance?

What job function(s) is/ are the employee having trouble performing because of the limitation(s)?

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How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

Section 3: Physician's Recommendations

Please provide any suggestions regarding possible reasonable accommodations to remove barriers. Provide as much detail as possible.

Section 4: Additional Comments

Please provide any additional information or comments.

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Print Professional's Name:	**Professional's Signature:**
Professional's License Number:	**Date Form Completed:**

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