Human Resources

Employee Reasonable Accommodation Request Form

If you are employed by Dakota State University (DSU) and are requesting reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA), the ADA Amendments Act of 2008 (ADAAA), and/or Section 504 of the Rehabilitation Act, you should complete this form in its entirety IF:

- You have a physical or mental impairment that substantially limits one or more major life activities, including but not limited to caring for oneself, performing manual tasks, seeing, hearing, breathing, eating, sleeping, walking, talking, etc.;
- You need the accommodation, given your impairment, to perform the essential functions of your position with DSU, or to enjoy the same benefits and privileges of employment at DSU as non-disabled employees; AND
- Your condition or the need for the accommodation is not already known or obvious to DSU.

If you are unable to complete this form on your own, someone else may complete the form on your behalf.

Medical information shared with the University through the ADA/ADAAA evaluation and/or reasonable accommodation process will be maintained separate from personnel files and in accordance with all ADA/ADAAA requirements. Specifically, such information will be treated as a confidential medical record. DSU may share such information only in limited circumstances with individuals who need to know, including your supervisors, first aid and safety personnel, government officials investigating compliance issues, worker's compensation offices, insurance carriers, health care professionals and HR personnel. For additional information on confidentiality protections, please contact Alicia Entringer, at 605-256-5762.

EMPLOYEE INFORMATION	
Date Requested:	Department/Unit:
Employee Name:	Position/Title:
Email Address:	Supervisor Name:
Phone/Ext:	Supervisor Phone:

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ACCOMMODATION REQUEST DETAILS

TO BE COMPLETED BY EMPLOYEE:

Please describe the disability for which you are requesting an accommodation:

Please indicate whether this disability is temporary (if temporary, give estimated duration) or permanent, and provide the date of diagnosis:

Please describe in detail how your disability affects your ability to perform the essential functions of your position. If you are a new employee, please state the anticipated difficulties you foresee in completing your essential job duties. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing. Note: Essential functions are duties that are basic or fundamental to a position.

Please describe the reasonable accommodation(s) you are requesting and how the accommodation(s) will aid you in performing your duties:

Employee Signature: _____ Date: _____

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RELEASE OF INFORMATION

TO BE COMPLETED BY EMPLOYEE:

Employee Name: _____ Department/Unit:_____

Position/Title: _____

I give authorization for my physician/care provider to release medical information to the Dakota State University Office of Human Resources for the purpose of determining qualification and reasonable accommodation under the Americans with Disabilities Act (ADA).

Employee Signature: _____ Date: _____

Please submit the completed form to the Human Resources by fax to (605) 256-5032, via mail or in person to:

DSU Human Resources Office
820 N Washington Ave
Madison, SD 57042

DAKOTA STATE UNIVERSITY

EMPLOYEE MEDICAL CERTIFICATION FORM FOR REASONABLE ACCOMMODATION(S)

Date: _____

Employee Name: _____ **Date of Birth:** _____

The **Genetic Information Nondiscrimination Act of 2008 (GINA)** prohibits employers 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.

A request for reasonable accommodation has been made by the employee named above. The information requested on this form will assist in making a determination regarding the employee's request. A Release of Information form is attached to this document.

Please complete the following form with information that pertains only to the condition for which the employee is requesting reasonable accommodation(s) under the Americans with Disabilities Act (ADA), as amended, and Section 504 of the Rehabilitation Act. Where such a condition or the need for the accommodation is known to DSU or is obvious, please contact the DSU Human Resources Office before attempting to fill out this form.

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Provider Name (please print): _____

Type of Practice/Specialty: _____

Business Address: _____

Phone: _____ Email Address: _____

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EMPLOYEE MEDICAL CERTIFICATION FORM FOR REASONABLE ACCOMMODATION(S)

TO BE COMPLETED BY HEALTHCARE PROVIDER:

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

2. If yes, please describe the mental or physical impairment.

3. Please describe the effects or limitations this impairment has on the employee's major life activities, if any.

4. Please describe whether the effects or limitations of this impairment are permanent, long-term, or short-term/temporary.

5. How does the employee's limitation(s) interfere with his or her ability to perform the essential functions of the position? (*If the employee does not provide you with a position description, please discuss position responsibilities and essential functions with the employee.*)

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6. Are there any work activities or job duties that would present a health or safety risk to the employee or others due to the impairment or its treatment?

7. Is the employee able to perform the essential functions of the position with or without reasonable accommodation(s)?

8. Please provide any suggestions for possible reasonable accommodation(s) that will enable the employee to perform the essential functions of the position. Please include the duration for which the reasonable accommodation(s) would be needed and how the potential accommodation(s) would improve job performance.

Signature of Healthcare Provider: _____ Date: _____

The physician/care provider or the employee may submit the completed form via email to Alicia Entringer at Alicia.Entringer@dsu.edu, by fax to (605) 256-5032, or in person to:

Alicia Entringer
DSU Human Resources Office
820 N Washington Ave
Madison, SD 57o42