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.

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<tr>
<th>EMPLOYEE INFORMATION</th>
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<tr>
<td>Date Requested:</td>
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<td>Employee Name:</td>
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<td>Email Address:</td>
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<td>Phone/Ext:</td>
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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: __________
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
EMPLOYEE MEDICAL CERTIFICATION FORM FOR REASONABLE ACCOMMODATION(S)

Date: ______________________________
Employee Name: ___________________________________ Date of Birth: _________________________

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: _______________________________________
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.)
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 57042