Western Illinois University

EMPLOYEE REQUEST FOR REASONABLE ACCOMMODATION/AUTHORIZATION FORM

PART A: **Employee Information**: This form is completed by an employee or faculty who is requesting accommodation(s) for performing essential job duties. Sign and forward the completed form to the Office of Equal Opportunity and Access (EOA) for review and approval.	
Employee Name/Title:	**Employee Type:** **____ Admin Professional ____ Civil Service ____ Faculty**
Campus: ____ Macomb ____Quad Cities	**Department and Building**:
Phone Number:	**Email**:

PART B: **Declaration of Disability and Request for Accommodation**: In accordance with the Americans with Disabilities Act, as amended, an employee with a disability has an impairment that substantially limits one or more major life activities or has a record of such an impairment. The information you provide will be used in discussions with the Office of Equal Opportunity and Access and Human Resources to determine if a reasonable accommodation will assist you to complete the essential job duties assigned to your position. Your treating health care provider may need to complete the ADA Medical Certification Form as advised by EOA and OHR. You may include attachments as needed.	
Describe your physical or mental impairment(s).	
How do/does the impairment(s) interfere with your completion of essential job duties or your ability to participate in other privileges of employment?	
What accommodation(s) are you requesting?	
How will the accommodation(s) assist you to complete your essential job duties?	

PART C: Employee Authorization for Medical Release:

- I authorize my treating health care provider to release to the EOA and/or the OHR at Western Illinois University, information which shall be required with respect to my disability and the accommodation(s) being requested. The University representatives may contact my physician to follow-up on or clarify the information provided.
- I acknowledge that my treating health care provider may need to complete the ADA Medical Certification Form as requested by the EOA or OHR specific only to my request for job accommodation(s).
- This information will be reviewed by EOA/OHR and maintained in a confidential and secured location.
- Managers and supervisors may receive instructions related to the final determination on a need-to-know basis only.
- My signature below certifies that the information I have provided is a truthful and accurate.

Employee Signature	**Date** (Month/Date/Year)

Western Illinois University

TREATMENT PROVIDER
ADA MEDICAL CERTIFICATION FORM

Part A. An employee within our organization is requesting reasonable accommodations. Please review the attached description of the employee's job duties and the related physical and mental functions required to perform these duties. The information you provide will be used to determine if accommodations can be provided. Thank you.

Employee Name:	Date of Request:

Does the employee have a physical or mental disability?	Yes ☐	No ☐
If *yes*, what is the impairment or the nature of the disability?		

Part B. Answer the following question based on what limitations the employee has when the condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population?	Yes ☐	No ☐
OR Describe how the disability impacts a major life activity when it is active. .	Note: It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity; the manner in which the individual performs the major life activity; and/or the duration of time it takes the individual to perform the major life activity, or for which the individual can perform the major life activity.	

What major life activity(s) and/or major bodily function(s) is/are affected? **Check all that apply**.

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking
☐ Breathing	☐ Interacting with Others	☐ Reading	☐ Standing
☐ Caring for Self	☐ Learning	☐ Seeing	☐ Thinking
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working (Describe)
☐ Other (Describe):			
☐			

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 & Skin
- ☐ Other (Describe):

Part C. An employee with a disability is entitled to an accommodation only when it is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with the employee's completion of job duties or accessing a benefit of employment?

What job function(s) or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?

Western Illinois University

Part D. If an employee has a disability and needs an accommodation(s) because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations? Please elaborate.
How will the suggested accommodation(s) impact the employee's ability to complete essential job duties?

Please use this space to document any additional comments?

Name and Title of Treating Physician	Phone Number and Email:

Treating Physician's Signature (Above)	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.

Western Illinois University
Office of Equal Opportunity and Access (EOA)
1 University Circle
Sherman Hall, Room 312
eoa-office@wiu.edu
(309) 298-1977