**Slippery Rock University of Pennsylvania**

## Requesting a Reasonable Accommodation

In accordance with the Americans with Disabilities Act of 1990 ("ADA"), the Pennsylvania Human Relations Act, and Slippery Rock University policies and practices, Slippery Rock University is prohibited from discriminating in employment against qualified individuals with disabilities on the basis of disability. It is the policy of Slippery Rock University of Pennsylvania to provide reasonable accommodations in compliance with federal and state law.

A reasonable accommodation is a modification or adjustment to a job, the work environment, or the way things are usually done that enables a qualified individual with a disability to enjoy an equal employment opportunity. An equal employment opportunity means an opportunity to attain the same level of performance or to enjoy equal benefits and privileges of employment as are available to an average similarly-situated employee without a disability. The ADA requires reasonable accommodation to ensure equal opportunity in the application process, to enable a qualified individual with a disability to perform the essential functions of a job, and to enable an employee with a disability to enjoy equal benefits and privileges of employment.

It is the responsibility of individual applicants and employees to disclose a disability or medical condition and request an accommodation. It is also the responsibility of individual employees to provide documentation of their disability (from an appropriately licensed professional) and to demonstrate how the disability limits their ability to complete the essential functions of their job. Medical documentation will be kept confidential and in a file separate from the employee's personnel file. **To request an accommodation, please refer to the attached form.** Questions about completing the form should be directed to:

Office of Human Resources
205 Old Main Building
(724) 738-2070

Once a completed request for an accommodation is received, the University engages in an interactive process with an employee and their supervisor to identify the most appropriate accommodation(s) in a given situation. Accommodations are made on a case by case basis, taking into account the type and severity of the disability and the specific job requirements involved.

If the employee disagrees with the accommodation selected or has been denied an accommodation to which the employee believes they are entitled under federal or state law, the employee may appeal the decision to the Chief Human Resources Officer, 205 Old Main Building within 7 working days of the date of the decision.

**Slippery Rock University of Pennsylvania**

**Reasonable Accommodation Request Form**

*This form must be completed by an employee requesting reasonable accommodation(s) under the American with Disabilities Act of 1990 ("ADA"), Pennsylvania Human Resources Act, and Slippery Rock University policies. Completed forms are to be returned to the Office of Human Resources.*

| | |
|---|---|
| 1. NAME | 2. DATE OF REQUEST |
| 3. JOB/POSITION TITLE | 4. DAYTIME TELEPHONE NO. |
| 5. DEPARTMENT NAME/ADDRESS | 6. EMAIL ADDRESS |
| 7. SUPERVISOR'S NAME | 8. SUPERVISOR'S TELEPHONE NO. |

*Please answer the following questions to assist the University in understanding the basis and nature of your request for an accommodation. The information you provide will be treated confidentially and will be handled on a need-to-know basis.*

1. Identify the physical and/or mental impairment(s) for which you are requesting accommodation and the expected duration of the accommodation.

2. Explain how the impairment(s) listed above affect(s) your ability to perform the essential functions of your position or access employment benefits. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

3. Describe any type of accommodation which you believe will enable you to perform the function of the position or access employment benefits.

4. Describe how this accommodation will assist you in performing the function of the position or access to employment benefits.

5. If you have had any accommodation in the past for this same limitation, describe those accommodations and how effective they were.

6. Do you have documentation to support your disability? YES _____ NO _____ If YES, please attach. [Documentation includes statements or other documentation from a physician or other professional identifying the disability and addressing what, if any, accommodations are necessary based upon your job duties. [See Medical Certification Form for additional information]. If you need a copy of a job description to provide to your medical professional, please contact Office of Human Resources, 205 Old Main, 724-738-2070.

**Acknowledgement**

I understand that it is my responsibility to complete the attached Release of Medical Information Statement and to provide a Medical Certification Statement to the Office of Human Resources for my request to be evaluated. I further understand that the Office of Human Resources will evaluate and respond to me based upon the information that I provide.

| | |
|---|---|
| SIGNATURE | DATE |
| RECEIVED BY HUMAN RESOURCES | DATE |

*Information or assistance regarding accommodation requests can be obtained by contacting:*

Office of Human Resources
205 Old Main Building
(724) 738-2070

## Release of Medical Information Statement

I, _____, understand that I am giving permission to Slippery Rock University of Pennsylvania Office of Human Resources to contact the following individual(s) for purposes of requesting documentation/information regarding my disability including the diagnosis and limitations associated with that diagnosis. I understand that this permission will remain in effect from the day I sign this document until I revoke permission in writing or am no longer affiliated with Slippery Rock University of Pennsylvania.

Name _____

Address _____

_____

Phone _____ E-mail _____

---

Name _____

Address _____

_____

Phone _____ E-mail _____

---

Name _____

Address _____

_____

Phone _____ E-mail _____

---

I understand that communication with the above-named individual(s) will not include personal disclosures that do not pertain to my identified disability(ies). I understand that all medical information related to my request for accommodation is confidential and will be maintained in a secured location within the Office of Human Resources separate and apart from my personnel file. I further understand that I will be required to provide the complete Medical Certification Form, attached, including the impact of functional limitations on my ability to perform the essential functions of my job.

| | |
|---|---|
| SIGNATURE | DATE |
| RECEIVED BY HUMAN RESOURCES | DATE |

## Medical Certification Form

Note: The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act ("ADA").

### To be completed by Employee

| | |
|---|---|
| 1. NAME | 2. JOB POSITION/TITLE |
| 3. SIGNATURE | 4. DATE |

### To be completed by Health Care Provider

The employee listed, above, is an employee of Slippery Rock University of Pennsylvania. The employee has requested an accommodation for a disability and has identified you as their health care provider. The employee claims to have the following condition(s):

_____

_____

and that this condition(s) requires an accommodation to enable them to perform the essential functions of their job. To assist the University in evaluating this request for accommodation, please provide detailed answers to the following questions, using additional sheets where necessary. The information you provide will be considered confidential and used only to evaluate the employee's request for accommodation.

*Please return the completed form to:*

Office of Human Resources
205 Old Main Building
(724) 738-2070
(724) 738-4475 (FAX)

***Please Note: 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 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.***

For reasonable accommodation under the ADA, an employee has a disability if the employee has an impairment that substantially limits one or more major life activities or a record of such an impairment.

1. Have you examined the employee for the above-stated condition? Yes _____ No _____
   Date of examination(s): _____

2. Does the employee have a "physical or mental impairment?" Yes _____ No _____

3. If you answered "yes" to question 2, please identify the employee's specific physical or mental impairment (diagnosis):

   _____
   _____
   _____
   _____
   _____

4. Does the above-identified impairment substantially limit a major life activity of the employee?

   Yes_____ No_____

5. If you answered "yes" to question 4, please describe what major life activity(ies) is substantially limited.

   _____
   _____
   _____
   _____
   _____

6. Please describe the manner and extent to which the impairment limits the above described major life activity(ies).

   _____
   _____
   _____
   _____
   _____

7. What is your prognosis for whether and in what manner the impairment will continue to limit the above-described major life activity(ies)?

   _____
   _____
   _____
   _____
   _____

8. What is the expected duration of the impairment?

_____
_____
_____
_____
_____

9. How does the impairment affect the employee's ability to perform the essential functions of the employee's job? (See attached job description). Please be specific.

_____
_____
_____
_____
_____

10. Please provide any additional medical information or documentation that you believe will assist the University in evaluating the impact of the employee's impairment; the activity or activities the impairment limits; and the extent to which the impairment limits the employee's ability to perform the activity or activities.

_____
_____
_____
_____
_____

11. Please list any accommodation(s) you believe would enable the employee to perform the essential functions of the employee's job.

_____
_____
_____
_____
_____

Thank you for completing this Medical Certification Form. The University will use the information you have provided to evaluate the employee's request for accommodation.

| | |
|---|---|
| 1. PHYSICIAN'S SIGNATURE | 2. DATE |
| 3. PHYSICIAN'S NAME | 4. TELEPHONE NUMBER |