BLUEFIELD STATE UNIVERSITY
ADA REASONABLE ACCOMMODATION REQUEST, MEDICAL VERIFICATION AND INQUIRY FORM

_____BSU Employee/Patient Name

Reasonable accommodations may be needed to provide equal access and opportunities to qualified individuals with disabilities. If you are a University employee with special needs that are the result of a disability and you believe that reasonable accommodations will assist you in the performance of your job, please follow the Instructions below for how to complete this form and return it to the address listed at the bottom of the page.

Instructions:

1. If you are a Bluefield State University employee requesting reasonable accommodation due to a disability, complete the employee information section of this form (**pages 1-3**).

2. Submit the form to your treatment provider so that s/he can complete the remainder of the form (**pages 4-7**). If you have different disabilities that are treated by different health care providers, please provide a form for each.

3. Return the completed form(s) (keep a copy for your records) to:

Vice President for Human Resources/ADA Coordinator
Bluefield State University Office of Human Resources
219 Rock Street, Bluefield, WV 24701
Phone: 304.327.4013 Fax: 304.327.4321 Email: ADACoordinator@bluefieldstate.edu

Office Hours: Monday – Friday 8:00 a.m. to 4:00 p.m.

REASONABLE ACCOMMODATION REQUEST
(To Be Completed by the Employee)

Employee Information

(PLEASE PRINT)

Employee Name: _____Employee ID#_____

Address: _____

City/State/Zip: _____

Department: _____Employee Phone#: _____

Employee's Job Title: _____

Employee's Work Schedule (days/hours; full-time; part-time): _____

Employee's Work location (Bldg; Rm#)_____

Supervisor: _____Supv. Phone#: _____

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1. Please describe the physical, mental, or cognitive impairment(s) that limit your ability to do your job.
2. Describe the accommodations you are requesting. Be as specific as possible (i.e., if you are requesting a piece of equipment or a device, please provide description, manufacturer, cost, where to order, etc.).
3. Describe how the requested accommodations will enable you to perform your job.

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4. Please provide any other information that might help Bluefield State University evaluate your request.

Employee Notice and Release
(A photo copy is as valid as the original)

The Americans with Disabilities Act (ADA) requires an employer to provide reasonable accommodation to an employee or job applicant with a disability, unless doing so would cause significant difficulty or expense for the employer. An employer doesn't have to provide an accommodation if doing so would cause undue hardship to the employer. Undue hardship means that the accommodation would be too difficult or too expensive to provide, in light of the employer's size, financial resources, and the needs of the business. An employer does not have to provide the exact accommodation the employee or job applicant wants. If more than one accommodation works, the employer may choose which one to provide.

I give Bluefield State University permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate University personnel and/or my health care provider. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job. I authorize Bluefield State University to obtain any medical documentation necessary to process this request. My health care provider(s) may release my health information to Bluefield State University. Bluefield State University may release my health information to others necessary to address my request for accommodation. I understand that this form needs to be completed in full and additional medical information may be required. Bluefield State University may request additional information from either me or my health care provider if needed. I am aware that Bluefield State University may also seek medical information from me or my health care provider(s) in order to assess employability options including accommodation or restriction from work. I understand that Bluefield State University will take the suggestions that my health care provider(s) make into consideration, but it is the employer's decision as to whether the accommodation(s) can be met in a reasonable fashion. A copy of this document may be accepted as the same as an original.

_____ _____

Employee Signature **Date**

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_____BSU Employee/Patient Name

REASONABLE ACCOMMODATION MEDICAL VERIFICATION & INQUIRY
(To Be Completed by the Employee's Treating Physician)

(PLEASE PRINT)

Employee/Patient Name_____

_____ **If checked, a copy of the employee's job description has been attached to assist you as the treating physician in completing the medical verification section of this form.**

A. Questions to help determine whether an employee has a disability.		
For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability:		
Does the employee have a physical or mental impairment?	Yes ☐	No ☐
If *yes*, what is the impairment?		
Answer the following question based on what limitations the employee has when his or her 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? *Note: Does not need to significantly or severely restrict to meet this standard. 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.*	Yes ☐	No ☐

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If *yes*, what major life activity(s) (includes major bodily functions) is/are affected?

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

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

B. Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation 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 job performance or accessing a benefit of employment?

Bending/Stooping	__ 0 hours	__ 1-3 hours	__ 3-5 hours	__ 5-8+ hours	__ No restriction
Pulling/Pushing	__ 0 hours	__ 1-3 hours	__ 3-5 hours	__ 5-8+ hours	__ No restriction
Overhead Reaching	__ 0 hours	__ 1-3 hours	__ 3-5 hours	__ 5-8+ hours	__ No restriction
Sitting	__ 0 hours	__ 1-3 hours	__ 3-5 hours	__ 5-8+ hours	__ No restriction
Standing	__ 0 hours	__ 1-3 hours	__ 3-5 hours	__ 5-8+ hours	__ No restriction

Other (Please describe):

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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?
C. Questions to help determine effective accommodation options.
If an employee has a disability and needs an accommodation 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 to improve job performance? If so, what are the suggested accommodations? *(Including but not limited to accommodations related to working hours per day, pulling/pushing, bending, stooping, sitting standing, lifting, overhead reaching and adaptive equipment.)*

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How would your suggested accommodations improve the employee's job performance?

D. Other comments.

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.

Certifying Health Care Provider's Information (Please Print unless indicated otherwise):

Health Care Provider's Name and Certification (M.D., D.O., etc.): _____

Health Care Facility Name (if applicable): _____

Street Address: _____

City/State/Zip: _____

Telephone: _____ **Facsimile:** _____

_____ _____

Treating Physician Signature **Date**

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