**REASONABLE ACCOMODATION REQUEST FOR EMPLOYMENT**

**CONFIDENTIAL**

The purpose of this form is to assist the University in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

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| **EMPLOYEE INFORMATION** | | | | | | | |
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| Employee Name: | |  |  | Department: | | |  |
| UW System Title: | |  |  | FTE %: | | |  |
| Working Title: | |  |  | Supervisor: | | |  |
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| **REQUEST** | | | | | | | |
| Please answer the following questions to assist us in understanding the basis and nature of your request for an accommodation (attach additional sheets if necessary). | | | | | | | |
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|  | What are the limitations caused by your condition(s) that you are currently experiencing? Identify the essential functions affected and be specific about how the medical condition impairs your ability in each instance. | | | | | | |
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|  | Given your limitations, what parts of your assigned job duties are impeded by your condition? | | | | | | |
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|  | Describe the accommodation you are requesting? | | | | | | |
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|  | Explain how the accommodation(s) you are requesting will enable you to perform the essential functions of your job? | | | | | | |
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|  | Will you be able to perform all the essential functions of your job if you receive the requested accommodations? If not, describe the functions you will not be able to perform. | | | | | | |
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|  | Do you need assistance to identify accommodations that will enable you to perform the essential functions of your job? If you do, explain what type of assistance you need. | | | | | | |
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|  | Provide any information or suggestion you can on how the requested accommodations(s) can be provided. If known, include the names, addresses and telephone numbers of vendors and model number and approximate cost of any equipment requested. | | | | | | |
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| **AUTHORIZATION** | | | | | | | |
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| By my signature below, I authorize the University of Wisconsin-Green Bay permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA). I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. | | | | | | | |
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| I further understand that I am required to complete and sign the attached release of information, giving UW-Green Bay permission to consult with my health care professional(s) in order to determine that I am a qualified employee with a disability and to seek guidance as to any functional limitations based on my disability. | | | | | | | |
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| *Employee Signature* | | | | |  | *Date* | |
| **FORWARD COMPLETED FORM TO HUMAN RESOURCES** | | | | | | | |

**AUTHORIZATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH INFORMATION**

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| I, , the undersigned, do hereby consent and authorize any health care providers, physicians, psychologists, psychiatrists, social workers who have treated me and hospitals in which I have been a patient, to disclose to the University of Wisconsin-Green Bay, or their representatives representing the State of Wisconsin, information from my health care records including my mental health/psychiatric care records relating to my diagnosis, prognosis or treatment. I understand the specific type of information to be disclosed includes but is not limited to physician and consultation reports, clinic records, lab, x-ray, and other test results, history reports, discharge summaries, psychiatric and/or psychologist evaluations. Information to disclose includes treatment for any drug, alcohol abuse, physical and mental conditions.  The purpose of this disclosure is to determine my functional abilities and limitations in relation to job functions.  I understand the protected health information to be disclosed pursuant to this Authorization may be subject to re-disclosure to individuals or organizations not subject to HIPAA and, therefore, may no longer be protected by HIPAA.  This authorization may be revoked by , upon written notification by me at any time, to the provider. A photocopy of this Authorization shall be considered as valid and acceptable as the original. | | | |
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| Healthcare Provider: |  | | |
| Address: |  | | |
| City, State, ZIP: |  | | |
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| Provider Phone Number: |  | | |
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| **AUTHORIZATION** | | | |
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|  | |  |  |
| *Employee Signature* | |  | *Date* |
| **PROVIDER** | | | |
| *Please return documentation to fax number or address below.* | | | |