

CONFIDENTIAL
THE UNIVERSITY OF WISCONSIN-GREEN BAY
Human Resources/Affirmative Action Office
Environmental Sciences 107
Reasonable Accommodation Request Form - Employment

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.

College/Administrative Area _____ Department/Unit _____

SECTION I: Employee: To be completed by employee requesting accommodation.

Employee: _____ Telephone: _____

Address: _____

Job Title: _____ Request Date: _____

Department Head/
Supervisor: _____ Telephone: _____

Address: _____

I give the University of Wisconsin-Green Bay Affirmative Action Office, permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. 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 am required to complete and sign the attached release of information giving UWGB 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.

_____ Date

_____ Employee's signature

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).

A. 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.

B. Given your limitations, what parts of your assigned job duties are impeded by your condition?

C. Describe the accommodation you are requesting.

D. Explain how the accommodation(s) you are requesting will enable you to perform the essential functions of your job.

- E. 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.

- F. 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.

- G. 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.

SECTION II: Employer: To be completed by employing department/unit.

Has the employee signed a Reasonable Accommodation Request Form (Section I)?

Yes No If no, request signature. (Copy to be given to the employee.)

Has a position description been completed? Yes No If no, complete a position description.

[Academic Staff/Limited and Faculty](#)

[Classified](#)

Send a copy of the signed Reasonable Accommodation Request Form and employee's current position description to the Affirmative Action Office at Environmental Sciences 107.

SECTION III: Affirmative Action Office: To be completed by AAO Staff.

Send a copy of:

1. The signed Health Care Provider Release Form
2. Position description
3. Cover letter

to the health care provider(s).

After receiving documentation from the health care provider(s):

Has a health care provider documented that the employee has a physical or mental impairment that substantially limits the employee's ability to perform essential job functions?

Yes No If yes,

Recommendations:

Accommodation Request is: Approved Denied Other

List specific reasonable accommodation(s) approved:

Name of person completing form:		Telephone:
Date:	Estimated cost of accommodation if known:	

Forward a copy of this form to the Affirmative Action Office at Environmental Sciences 107. If you have any questions, please contact Human Resources (920) 465-2390.

THE UNIVERSITY OF WISCONSIN-GREEN BAY
Office of Human Resources and Affirmative Action
Authorization and Informed Consent for Disclosure of Health Information

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 redisclosure 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.

Address of Healthcare Provider:

Phone Number:

Employee Signature

Authorization Date