Application #

Application to Request a Reasonable Accommodation of a Disability

Application for reasonable accommodation may be made to a supervisor or an Affirmative Action Administrator (AAA). If the request is made to a supervisor, the supervisor will forward the request to the AAA. **All confidential information received by OPWDD personnel pertaining to your request shall be handled as such.** All medical information is confidential and maintained separately from personnel records.

Section A

(To be completed by employee and returned to the AAA.)

Name:	**Civil Service Title:**	**Job Title *(If different)*:**
Work Location:	**Shift:**	**Pass Days:**
Work Email:	**Work Phone *(Including area code)*:**	**Home Phone *(Including area code)*:**
Home Address:	**City, State, Zip Code:**	**Cell Phone *(Including area code)*:**
Supervisor's Name:	**Supervisor's Phone *(Including area code)*:**	
Team Leader/Dept. Head/Manager Name:	**Team Leader/Dept. Head/Manager Phone *(Including area code)*:**	

Preferred method of communication ☐ Email ☐ Phone

I am requesting the following reasonable accommodation(s):
It is necessary for me to have this accommodation for the following reason(s): <u>(See attached Medical Form)</u>

Employee Signature:	**Date:**
Received by AAA Signature:	**Date:**

cc: ***Supervisor***

The employee should retain a copy of this form. The original is filed by the AAA.

<u>Please submit with OPWDD Reasonable Accommodation Medical form.</u>

Application #

REQUEST FOR REASONABLE ACCOMMODATION
Medical Form

(To be completed by Physician or a Qualified Professional)
(To be accompanied by Reasonable Accommodation application.)

Patient Name	Name, Address and Telephone Number of Physician
Employment Position Title: ☐ DIRECT SUPPORT ☐ OTHER	
Requested Accommodation	

INSTRUCTIONS: The above-named patient, an OPWDD employee, has requested that he/she be provided with the accommodation set forth above with respect to his/her work duties. In order for OPWDD to evaluate the same, please:

1. Identify the patient's disability, if any:

2. Identify the specific functional limitations imposed by that disability, if any:

3. Identify the precise job limitations imposed by the disability, if any. (For positions involving physical work duties, please complete the attached **Physical Capabilities** section at the end of this form.)

4. State whether the patient requires an accommodation for the performance of his/her duties, the type of accommodation required and the reason why such accommodation is needed:

5. Estimate the frequency it is anticipated that the patient will require such accommodation and why:

6. Estimate the duration of time the patient will require the accommodation and why:

PLEASE COMPLETE ESTIMATED PHYSICAL CAPABILITIES EVALUATION BELOW FOR POSITIONS INVOLVING PHYSICAL WORK DUTIES ONLY

1.a. In an eight-hour workday, how many hours can this employee: (Please circle appropriate number.)

Sit	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐	☐ Continuously	☐ With Rests
Stand	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐	☐ Continuously	☐ With Rests
Walk	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐	☐ Continuously	☐ With Rests

b. In a given day, for how many total hours can this employee sit, stand, and or walk in combination?

4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐

2. Other capabilities: (Please check appropriate boxes.)

	Never	Occasionally	Frequently	Continuously
Lift	☐	☐	☐	☐
00-10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100	☐	☐	☐	☐
Carry	☐	☐	☐	☐
00-10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Run	☐	☐	☐	☐
Reach above Shoulder level	☐	☐	☐	☐
Operate a Motor vehicle	☐	☐	☐	☐

Upper Extremities:

Which hand is dominant? Right ☐ Left ☐

Can this employee perform repetitive actions such as?

	Simple Grasping	Pushing & Pulling	Fine Manipulation
Right	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Left	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Lower Extremities:

Use of feet/legs for repetitive movement, as in Operation of foot controls and motor vehicles.

Right Extremity	Left Extremity	Simultaneous
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

3. Work Environment Restrictions:
Can this employee:

- o Be exposed to marked changes in temperature and humidity? Yes ☐ No ☐
- o Be exposed to unprotected heights? Yes ☐ No ☐
- o Be around moving machinery? Yes ☐ No ☐

4. Could this employee intervene physically with a person requiring a restraint? ☐Frequently ☐Occasionally ☐Seldom
Please explain:

5. Other Restrictions:

PHYSICIAN'S SIGNATURE _____ DATE _____

Please return to: _____
ADA Coordinator

Mailing Address:

Phone: _____ _____

Fax: _____ _____

_____