MONTGOMERY COLLEGE

EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM

This form is to be completed by employees when requesting an accommodation, or modified accommodation under the Americans with Disabilities Act (ADA) of 1990. Upon completion, return all documentation to:

ADAACCOMMODATIONS@MONTGOMERYCOLLEGE.EDU

PART 1: TO BE COMPLETED BY THE EMPLOYEE

Name: _____ Telephone: _____

Address: _____ Position/Grade: _____

Supervisor: _____ Department: _____

Accommodation Requested:

The ADA does not require that a specific or requested accommodation be granted but rather that an appropriate, reasonable accommodation be made to a qualified individual with a disability. The College will make every effort to reasonably accommodate an employee who has a disability that prevents him/her from fully carrying out the duties of his/her position. Every effort will be made to involve the individual with a disability in identifying and implementing reasonable accommodations.

PART II: To be completed by Human Resources:

Date request received: _____

Intake Interview Conducted by HR Specialist: _____

HR Specialist initials: _____ Date of interview: _____

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PART III: Medical Certification of Disability - To be completed by Health Care Provider:

The Americans with Disabilities Act (ADA) of 1990, requires employers to make reasonable accommodations for a qualified individual with a disability. According to the ADA, an individual with a disability is one who:

- Has a physical or mental impairment that substantially limits a major life activity;
- Has a record of a substantially limiting impairment;
- Is regarded as having a substantially limiting impairment."

I certify that _____has met the definition of individual with a disability based on objective medical evidence and is medically suitable for reasonable accommodations.

Reasonable Accommodation: _____

Recommendation: _____

Alternative Placement: _____

Job Modification: _____

Assistive Devices: _____

Other (explain) Comments

_____ _____

Employee Medical Examiner Date

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PART III (cont): Medical Certification of Disability - To be completed by Health Care Provider:

Please feel free to use attachments for your responses.

1. Diagnosis, date of onset

2. Prognosis

3. Treatment, hospitalizations?

4. Functional limitations/restrictions to employment. Please indicate below

   Temporary, if temporary what is the duration?

   Permanent

   Unknown

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5. Describe in detail the employee's symptoms.

6. Describe how the condition limits the employee's major life activities, such as walking, talking, seeing, hearing, speaking, breathing, learning, caring for oneself, performing manual tasks, and/or working.

7. Where does the employee experience symptoms specific to his/her medical condition (e.g. indoors at work, outdoors at home, outdoors at work, in air-conditioned or non-air-conditioned places.

8. Are there any temperature extremes or other environmental conditions that the employee needs to avoid, such as dust, fumes, smoke, chemicals, hot weather, cold weather?

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9. Does the employee have any allergies?

If so, where does the employee exhibit symptoms; at home only, at work only, both at home and at work? Has the employee been tested for allergies? If so, what allergies has he/she been tested for and what were the results? (Please attach a copy of the results)

10. Does the employee's medical condition preclude the employee from performing any job tasks and/or activities, as described by the attached job position description?

If so, please describe in detail the job tasks that this employee is restricted from performing.

11. Does the employee's medical condition preclude the employee from an assignment in any particular work environment? If so, please explain now, in detail.

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12. Does the employee take any medications that could affect the employee's job performance? Will this medication affect the employee's ability to drive, operate heavy machinery, or perform the essential functions of the job described in the attached description?

13. Does the employee have any functional limitations to employment presented by mental illness? If so, please describe in detail what major life activity is substantially limited?

ADDITIONAL COMMENTS:

Health Care Provider Print Name _____

Health Care Provider Signature _____

Telephone: _____

Date: _____