



ADA ACCOMMODATION REQUEST FORM

Montgomery College is committed to diversity and nondiscrimination and supports employment opportunities for qualified individuals with disabilities in accordance with the College's Affirmative Action Plan for Veterans and Individuals with Disabilities, Board policy on Equal Employment Opportunity and Non-Discrimination, and state and federal laws and regulations, including the Americans with Disabilities Act of 1990.

PART I: To be completed by employee

Name: _____ Telephone: _____

Address: _____ Position: _____

Supervisor: _____ Department: _____

Accommodation Requested:

The Americans with Disabilities Act (ADA) does not mandate that a specific accommodation requested by an employee must be granted. Instead, it requires that a reasonable and appropriate accommodation be provided to qualified individuals with disabilities.

Montgomery College is committed to making every reasonable effort to accommodate employees whose disabilities prevent them from fully performing the essential functions of their positions. The College also values collaboration and will actively involve the employee in identifying and implementing suitable accommodations.

PART II: To be completed by Human Resources:

Date request received: _____

Intake interview conducted by HR Specialist: _____

Date of interview: _____



PART III: Medical certification of disability to be completed by health care provider

PART III-A:

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:

PART III-B:

Please feel free to use attachments for your responses.

1. Diagnosis, date of onset
2. Prognosis

<p>3. Treatment, hospitalizations?</p>
<p>4. Functional limitations/restrictions to employment. Please indicate below.</p>
<p>5. Describe in detail the employee's symptoms.</p>
<p>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.</p>
<p>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-airconditioned places)?</p>
<p>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?</p>

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 employees medical condition preclude the employee from as assignment in any particular work environment? If so, please explain in detail.

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 Name

Telephone

Signature

Date

Completed forms should be submitted to:

ADAAccommodations@montgomerycollege.edu

Do not include any other recipients when transmitting medical documents.