Appendix A

## Reasonable Accommodation Request Form

*This form must be completed by an employee requesting reasonable accommodation(s) under the American with Disabilities Act of 1990 ("ADA"), Pennsylvania Human Resources Act, and Pennsylvania Western University policies. Completed forms are to be returned to the Office of Compliance and Title IX* at ADARequest@pennwest.edu.

| | |
|---|---|
| 1. NAME | 2. DATE OF REQUEST |
| 3. JOB/POSITION TITLE | 4. DAYTIME TELEPHONE NO. |
| 5. DEPARTMENT NAME/ADDRESS | 6. EMAIL ADDRESS |
| 7. SUPERVISOR'S NAME | 8. SUPERVISOR'S TELEPHONE NO. |

*Please answer the following questions to assist the University in understanding the basis and nature of your request for an accommodation. The information you provide will be treated confidentially and will be handled on a need-to-know basis.*

1. Identify the physical and/or mental impairment(s) for which you are requesting accommodation and the expected duration of the accommodation.

2. Explain how the impairment(s) listed above affect(s) your ability to perform the essential functions of your position or access employment benefits. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

3. Describe any type of accommodation which you believe will enable you to perform the function of the position or access employment benefits.

4. Describe how this accommodation will assist you in performing the function of the position or access to employment benefits.

5. If you have had any accommodation in the past for this same limitation, describe those accommodations and how effective they were.

6. Do you have documentation to support your disability? YES ☐ NO ☐ If YES, please attach. [Documentation includes statements or other documentation from a physician or other professional identifying the disability and addressing what, if any, accommodations are necessary based upon your job duties. [See Medical Certification Form for additional information]. If a staff member needs a copy of a job description to provide to your medical professional, please contact the Office of Human Resources at HR@pennwest.edu

**Acknowledgment**

I understand that it is my responsibility to complete the attached Release of Medical Information Statement and to provide a Medical Certification Statement to the Office of Compliance and Title IX for my request to be evaluated. I further understand that the Office of Compliance and Title IX will evaluate and respond to me based upon the information that I provide.

| | |
|---|---|
| SIGNATURE | DATE |
| RECEIVED BY COMPLIANCE and TITLE IX | DATE |

*Information or assistance regarding accommodation requests can be obtained by contacting the*- Office of Compliance and Title IX, ADARequest@pennwest.edu or 814-393-2109.

## Release of Medical Information Statement

I, _____, understand that I am giving permission to Pennsylvania Western University of Pennsylvania Office of Compliance and Title IX to contact the following individual(s) for purposes of requesting documentation/information regarding my disability including the diagnosis and limitations associated with that diagnosis. I understand that this permission will remain in effect from the day I sign this document until I revoke permission in writing or am no longer affiliated with Pennsylvania Western University of Pennsylvania.

Name _____

Address _____

_____

Phone _____ E-mail _____

---

Name _____

Address _____

_____

Phone _____ E-mail _____

---

---

I understand that communication with the above-named individual(s) will not include personal disclosures that do not pertain to my identified disability(ies). I understand that all medical information related to my request for accommodation is confidential and will be maintained in a secured location within the Office of Compliance and Title IX separate and apart from my personnel file. I further understand that I will be required to provide the complete Medical Certification Form, attached, including the impact of functional limitations on my ability to perform the essential functions of my job.

| | |
|---|---|
| SIGNATURE | DATE |
| RECEIVED BY COMPLIANCE and TITLE IX | DATE |

# Medical Certification Form

Note: The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the Americans with Disabilities Act ("ADA").

## To be completed by Employee

| | |
|---|---|
| 1. NAME | 2. JOB POSITION/TITLE |
| 3. SIGNATURE | 4. DATE |

## To be completed by Health Care Provider

The employee listed, above, is an employee of Pennsylvania Western University of Pennsylvania. The employee has requested an accommodation for a disability and has identified you as their health care provider. The employee claims to have the following condition(s):

_____

_____

and that this condition(s) requires an accommodation to enable them to perform the essential functions of their job. To assist the University in evaluating this request for accommodation, please provide detailed answers to the following questions, using additional sheets where necessary. The information you provide will be considered confidential and used only to evaluate the employee's request for accommodation.

*Please return the completed form to* Office of Compliance and Title IX, ADARequest@pennwest.edu.

***Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.***
***'Genetic Information' as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.***

For reasonable accommodation under the ADA, an employee has a disability if the employee has an impairment that substantially limits one or more major life activities or a record of such an impairment.

1. Have you examined the employee for the above-stated condition? Yes ☐ No ☐
   Date of examination(s): _____

2. Does the employee have a "physical or mental impairment?" Yes ☐ No ☐

3. If you answered "yes" to question 2, please identify the employee's specific physical or mental impairment (diagnosis):

   _____
   _____
   _____
   _____
   _____

4. Does the above-identified impairment substantially limit a major life activity of the employee?

   Yes ☐ No ☐

5. If you answered "yes" to question 4, please describe what major life activity(ies) is substantially limited.

   _____
   _____
   _____
   _____
   _____

6. Please describe the manner and extent to which the impairment limits the above described major life activity(ies).

   _____
   _____
   _____
   _____
   _____

7. What is your prognosis for whether and in what manner the impairment will continue to limit the above-described major life activity(ies)?

   _____
   _____
   _____
   _____
   _____

8. What is the expected duration of the impairment?

_____
_____
_____
_____
_____

9. How does the impairment affect the employee's ability to perform the essential functions of the employee's job? (See attached job description). Please be specific.

_____
_____
_____
_____
_____

10. Please provide any additional medical information or documentation that you believe will assist the University in evaluating the impact of the employee's impairment; the activity or activities the impairment limits; and the extent to which the impairment limits the employee's ability to perform the activity or activities.

_____
_____
_____
_____
_____

11. Please list any accommodation(s) you believe would enable the employee to perform the essential functions of the employee's job.

_____
_____
_____
_____
_____

Thank you for completing this Medical Certification Form. The University will use the information you have provided to evaluate the employee's request for accommodation.

| 1. PHYSICIAN'S SIGNATURE | 2. DATE |
|---|---|
| 3. PHYSICIAN'S NAME | 4. TELEPHONE NUMBER |