CSUDH | HUMAN RESOURCES MANAGEMENT

1000 East Victoria Street, WH 340
Carson, California 90747
PHONE: (310) 243-3771 FAX: (310) 928-7256

REASONABLE ACCOMMODATION REQUEST FORM FOR EMPLOYEES AND APPLICANTS

Date Accommodation Needed:_____ Date of Disability Onset:_____

Employee Name:_____ Employee Phone: _____

Employee Address: _____ Employee ID: _____

Position Title: _____ Hours Per Day: _____ Department Name:_____

Workspace Location (Building, Floor, Suite):_____ Is this request due to a work-related injury? Yes ○ No ○

Appropriate Dept. Administrator's Name: _____ Dept. Administrator's Ext:_____

Primary Treating Physician Name:_____ Physician's Phone:_____

A "reasonable accommodation" is a modification or adjustment to a job, the work environment, or the way things usually are done, that enables a qualified individual with a disability to enjoy an equal employment opportunity.

The purpose of an accommodation is to assist an individual with performing the essential functions of their job. Reasonable accommodations may include but are not limited to: a modified/transitional work schedule, provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee's position or a leave of absence to allow time for recovery, therapy, training, or other disability-related needs. The Appropriate Administrator of your department will decide whether an accommodation can be provided.

I am requesting a reasonable accommodation for the following reason: (Choose Only One)

○ I am applying for employment and a reasonable accommodation is necessary in order to comply with your application procedures and/or to safely and effectively perform the essential functions of the desired position listed above.

○ I am a current employee of CSUDH and I am requesting a reasonable accommodation in order to perform the essential functions of my existing position.

○ I am a current employee of CSUDH and I am applying for alternate position within the organization. A reasonable accommodation may be necessary to ensure I can safely and effectively perform the essential functions of the position I am applying for.

1. Are you currently in active treatment with a healthcare professional? Yes ○ No ○

2(a). Is your need for an accommodation temporary ○ or permanent ○?
2(b). If temporary, what is the expected end date of the need for the accommodation?:_____

3. Are there limitations on employee's abilities to perform essential functions? *Please do not disclose diagnosis*

4. Please list the specific essential job functions you are unable to perform due to your limitations: (Ex: filing, using copier, digging, use of heavy equipment; use of chemicals)

5. Which area of your job do you need to modify? (List: job tasks, job hours, parking location etc.)

6. What suggestions for modifying your job do you have to ensure you have the ability to perform the essential function of your job?

7. Have you had any reasonable accommodations in the past for this same limitation(s) which were effective? Yes ◯ No ◯

8. If yes, please explain:

You may provide a copy of your position description to your Treating Physician to assist with their review for consideration for an accommodation. If you need a copy of your position description:

- **Staff may request a copy of their position description from Human Resources**
- **Faculty may request a copy of their position description from Faculty Affairs.**

I verify that the above information is true and correct to the best of my knowledge and agree to allow this information be reviewed by the necessary parties to enable my accommodation. I understand that electronic copies of medical notes I submit to Human Resources will be maintained electronically in a separate, secure file contained in Human Resources in accordance HIPAA regulations.

_____ _____

Employee Name (Print) Employee Signature and Date

I acknowledge the employees request.

_____ _____

Appropriate Dept. Administrator Name (Print) Appropriate Dept. Administrator Signature & Date

Questions please all ADA Coordinator at ext. 3694

The information requested above is CONFIDENTIAL and will be used to determine an appropriate reasonable accommodation for your work-related limitations due to a qualifying disability. This form is to be completed by the employee or a representative acting on behalf of the employee, and provided to Human Resources. Please submit the completed form by email ADAAccommodations@csudh.edu. You may also deliver the completed form to Human Resources, Welch Hall 340, Phone (310) 243-3694.

Or send via U.S. mail to:

California State University, Dominguez Hills
Human Resources
Attention: ADA Coordinator
1000 E. Victoria Street, WH 340
Carson, CA 90747

*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 this 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 or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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MEDICAL RECORDS RELEASE AUTHORIZATION:

I, _____, hereby authorize California State University, Dominguez Hills, or its agent, to contact my physician/health care provider. I authorize my physician/health care provider to release information pertaining to my accommodation request to California State University, Dominguez Hills, Human Resources, about my functional abilities/limitations with relation to my job duties.

I hereby acknowledge I have been informed of my right to receive a copy of this authorization upon request. I further acknowledge I have been informed if the medical information covered herein is not released, my request for a reasonable accommodation may be denied. I understand this authorization shall become effective immediately upon execution.

Employee Signature _____ Date _____

Return this form to:

Human Resources, California State University Dominguez Hills
1000 E. Victoria Street, WH 340
Carson, CA 90747

Or send via secured email to:

ADAAccommodations@csudh.edu.

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