

## **PROCEDURES FOR REQUESTING REASONABLE ACCOMMODATION**

### ***FOLLOW THESE STEPS WHEN AN EMPLOYEE RAISES MEDICAL OR ENVIRONMENTAL FACTORS AS A CONCERN IN JOB PERFORMANCE OR CONDUCT***

STEP 1 – The employee/applicant completes Part I, Employee's Statement of Disability. The requesting employee's supervisor, or in the case of an applicant, the Personnel Director will review the form to determine if further action is necessary. Instruct the employee/applicant to use an additional piece of paper or the back of the form, if necessary, to completely answer the questions.

STEP 2 – The supervisor/Personnel Director completes Part II, Supervisor's Statement, to identify those performance, conduct or attendance problems the employee/applicant is experiencing.

STEP 3 – The employee/applicant provides acceptable medical evidence to support his/her claim to the employee's supervisor or Personnel Director, as appropriate. The supervisor/Personnel Director will provide Part III, Physicians Statement to the employee/applicant with a copy of the appropriate position/job description, performance elements and standards, and the physical and environmental factors identified for the position. Provide copies of Parts I and II to the physician, if appropriate.

STEP 4 – Provided the medical evidence is sufficient, the appropriate supervisor/Personnel Director will complete Part IV, Agency Certification of Accommodation Efforts. If any accommodation is made, a copy of Part IV should be mailed to the DoDEA Equal Employment Opportunity Office, ATTN: Disabilities Program Manager, 4040 North Fairfax Drive, Arlington, VA 22203-1634, or sent by facsimile to (703) 696-9059.

**PART I EMPLOYEE'S STATEMENT OF DISABILITY**

[In Connection with Requests for Reasonable Accommodation for Health Reasons.]

1. Name of Applicant (last/first/middle): \_\_\_\_\_
2. Date of Birth (month/day/year): \_\_\_\_\_
3. Social Security Number: \_\_\_\_\_
4. Position Title: \_\_\_\_\_
5. Grade/Series/Step: \_\_\_\_\_
6. Office/Department: \_\_\_\_\_
7. Work Phone Number: \_\_\_\_\_
8. DoDEA School District: \_\_\_\_\_
9. Immediate Supervisor's Name: \_\_\_\_\_
10. Immediate Supervisor's Phone Number: \_\_\_\_\_
11. Describe what your position requires you to do:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Describe the difficulties you are having in your position with respect to performance, attendance, or conduct.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Describe your medical condition(s) (i.e., disease or injury) and how (it/they) interfere(s) with the performance of your duties or your attendance or conduct:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Describe any other restrictions of your activities imposed by your medical condition(s) (i.e., disease or injury) which you believe should be considered in determining your ability to perform in other positions in your activity for which you may otherwise be qualified.

15. Give the approximate date (month/year) your medical condition began to affect your performance or conduct.

16. Have you been hospitalized for your medical condition (i.e., disease or injury) as described in item 11? Check one: \_\_\_\_\_ No \_\_\_\_\_ Yes

17. Describe specifically what accommodation(s) you think could be made so that you would be able to perform the essential duties of your position.

18. Have you previously applied for a limited duty assignment or special placement for health reasons? \_\_\_\_\_ No \_\_\_\_\_ Yes (If Yes, give reason and dates.)

19. Have you had a limited duty assignment or a special placement for health reasons?  
\_\_\_\_\_ No \_\_\_\_\_ Yes (If yes, give reasons and dates.)

20. I request [Check one.]:

- a.  Limited duty not to exceed ( ) 30 ( ) 60 ( ) 120 days.
- b.  Special accommodation for health reasons. My disability is expected to last beyond 120 days.
- c.  Special accommodation for health reasons. My disability is expected to be permanent.

**CERTIFICATION AND CONSENT BY EMPLOYEE**

I hereby certify that all statements made above are true to the best of my knowledge and belief. I hereby give my permission for the release of information about my service and medical condition(s) (i.e., disease and injury) to authorized agency officials.

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SIGNATURE (Do not print)                      Date                      Office Telephone Number

PART II – SUPERVISOR’S STATEMENT

In Connection with Employee’s Request for Reasonable Accommodation for Health Reasons

SECTION A – Information about Employee’s Performance/Conduct (if applicable).

**Are there any performance and conduct issues that would be relevant to the issue of accommodation for this employee?**

SECTION B – Accommodations.

**What efforts have you made to accommodate employee (including temporary accommodations, e.g., light duty)?**

SECTION C – Supervisor’s Certification.

**1. How long have you supervised employee? \_\_\_\_\_ Years \_\_\_\_\_ Months**

**2. Telephone Number: \_\_\_\_\_**

**I certify that all the statements made on this Supervisor’s Statement are true to the best of my knowledge and belief.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
(Typed Name)

\_\_\_\_\_  
Date

**PART III – PHYSICIAN’S STATEMENT**

In Connection with Employee’s Request for Reasonable Accommodation for Health Reasons

**SECTION A – Identifying Information and Consent (to be completed by employee).**

- 1. Applicant’s Name (Last, First, Middle): \_\_\_\_\_
- 2. Date of Birth (Month Day, Year): \_\_\_\_\_
- 3. Social Security Number: \_\_\_\_\_
- 4. Enter exact Name and Address (including Zip Code) of your employing agency.  
(Address to which physician sends statement).

**APPLICANT’S CONSENT TO RELEASE MEDICAL INFORMATION**

**I authorize the release to my employing activity of any and all information or records connected with my disease or injury.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

SECTION B – Medical Documentation (To be completed by Physician)

PATIENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

INSTRUCTIONS

The individual identified above is requesting medical documentation that will be evaluated, along with other information, in connection with his or her request for reasonable accommodation. The reasonable accommodation, if found to be medically warranted, could include one of several options (if possible), including restructuring of the current position or reassignment to a position which the employee is medically able to perform. A copy of the employee's position description and the critical elements and performance standards for the position are attached for your information. If the physical and environmental requirements identified for the position are also attached, these must specifically be addressed in your report.

The applicant is responsible for any cost incurred in connection with providing this documentation unless the Agency has specifically authorized payment.

A new medical examination is not necessary if you can provide current (not more than 3 months) information from your records.

Please provide the medical documentation requested under 'MEDICAL DOCUMENTATION REQUIREMENTS' on your letterhead stationary. It is important that you respond to every item marked. Enter the item number of the information requested and provide your response. If an item is not applicable to the applicant's medical condition, enter "Not Applicable."

Enclose your report and any attachments in a sealed envelope marked "DISABILITY – PRIVILEGED – PRIVATE." Send it to the address shown in Section A, Item 4. You may, if you wish, give it directly to the applicant for delivery to the employing office.

Please complete this statement within 2 weeks. Be sure to sign the report and include your telephone number.

### MEDICAL DOCUMENTATION REQUIREMENTS

PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. The history of the specific medical condition(s), including references to findings from previous examinations, treatments, and responses to treatment.
2. Clinical findings from the most recent medical evaluation including any of the following which have been obtained: findings of physical examination, results of laboratory tests, X-rays, EKGs and other special evaluations or diagnostic procedures and, in the case of psychiatric diseases, the findings of mental status examinations and the results of psychological tests.
3. Assessment of the current clinical status and plans for future treatment.
4. Diagnosis.
5. An estimate of the expected date of full or partial recovery.
6. An explanation of the impact of the medical condition on life activities, both on and-off the job.
7. Assessment of the degree to which the medical condition has or has not become static or well stabilized and an explanation of the medical basis for the conclusion.
8. The likelihood that the individual will suffer sudden or subtle incapacitation associated with the medical condition. Explain the medical basis for your conclusions.
9. The probability that the individual will suffer injury or harm if he or she is not restricted or accommodated. Explain the medical basis for your conclusion.
10. The medical basis for your decision to recommend or not to recommend restrictions that prohibit the individual from attending work altogether or performing specific duties of the position. If you have recommended any work-related restrictions or accommodations, explain the therapeutic or risk-avoiding value of the restrictions and whether you have recommended any similar restrictions on non-work-related activities.

PART IV – REASONABLE ACCOMMODATION REPORTING FORM

In Connection with Employee's Request for Reasonable Accommodation for Health Reasons

SECTION A – GRANTING A REASONABLE ACCOMMODATION REQUEST

Name of Individual requesting reasonable accommodation: \_\_\_\_\_

Office of Requesting Individual: \_\_\_\_\_

1. Reasonable accommodation: (check one)

\_\_\_\_\_ Approved

\_\_\_\_\_ Denied (If denied, attach SECTION B – DENIAL OF REASONABLE ACCOMMODATION REQUEST, page Appendix A-11).

2. Date reasonable accommodation requested: \_\_\_\_\_

Request received by \_\_\_\_\_

3. Date reasonable accommodation request referred to decision-maker (i.e., supervisor, Personnel Director) \_\_\_\_\_

Name of decision-maker: \_\_\_\_\_

4. Date reasonable accommodation approved or denied: \_\_\_\_\_

5. Date reasonable accommodation provided: \_\_\_\_\_

6. If time frames outlined in the Procedures to Facilitate the Reasonable Accommodation were not met, please explain why (use additional sheets, if necessary).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Job held or desired by individual requesting reasonable accommodation (including occupational series, grade level, and office):

\_\_\_\_\_

**8. Reasonable accommodation needed for: (*check one*)**

- Application process
- Performing Job Functions or Accessing the Work Environment
- Accessing a Benefit or Privilege of Employment (*e.g., attending a training program or social event*)

**9. Type(s) of reasonable accommodation requested (*e.g., adaptive equipment, staff assistant, and removal of architectural barrier*):**

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**10. Type(s) of reasonable accommodation provided (if different from what was requested):**

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**11. Was medical information required to process this request? If yes, explain why (*use additional sheets, if necessary*).**

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**12. Sources of technical assistance, if any, consulted in trying to identify possible reasonable accommodation (*e.g., Job Accommodation Network, disability organization, CAP*):**

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**13. Comments:**

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Submitted by: \_\_\_\_\_

Phone: \_\_\_\_\_

*Attach copies of all documents obtained or developed in processing this request.*

**SECTION B – DENIAL OF A REASONABLE ACCOMMODATION REQUEST**

*Complete Numbers 1-4, Complete Number 5, if applicable.*

**1. Name of Individual requesting reasonable accommodation:**

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**2. Type(s) of reasonable accommodation requested:**

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**3. Request for reasonable accommodation denied because (may check more than one box):**

- Accommodation Ineffective
- Accommodation Would Cause Undue Hardship
- Medical Documentation Inadequate
- Accommodation Would Require Removal of an Essential Function
- Accommodation Would Require Lowering of Performance or Production Standard
- Other (Please identify)

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**4. Detailed Reason(s) for the denial of reasonable accommodation (Must be specific, e.g., why accommodation is ineffective or causes undue hardship):**

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**5. If the individual proposed one type of reasonable accommodation, which is being denied, but rejected an offer of a different type of reasonable accommodation, explain both the reasons for denial of the requested accommodation and why you believe the chosen accommodation would be effective.**

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6. If an individual wishes to request reconsideration of this decision, s/he may take the following steps:

- Ask the decision-maker to reconsider his/her denial in writing. Additional information may be presented to support this request.
- If the decision-maker does not reverse the denial, and the decision-maker was the individual's supervisor, the individual may pursue the reconsideration through their chain of command.

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Typed Name of Deciding Official

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Signature of Deciding Official

Date reasonable accommodation denied: \_\_\_\_\_

## References

Executive Order 13164 of July 26, 2000, Requiring Federal Agencies to Establish Procedures To Facilitate the Provision of Reasonable Accommodation

Executive Order 13163 of July 26, 2000, Increasing the Opportunity for Individual With Disabilities To Be Employed in the Federal Government

EEOC Directive 915.003, October 20, 2000, EEOC Policy Guidance on Executive Order 13164: Establishing Procedures to Facilitate the provision of Reasonable Accommodation

EEOC Guidance. Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act

The Rehabilitation Act of 1973, Sections 501 and 505

The United States Equal Employment Opportunity Commission Technical Assistance Program, Disability Discrimination, January 2001