Reasonable Accommodation Form for Employees

The University requires the information below in order to assess your request for a reasonable accommodation. This initial information will be part of an interactive process with you as we evaluate your request. This form will be kept separate from your personnel file. The responses may generate the need for additional medical information.

Please access the following website for the ***Policy on Reasonable Accommodations for Employees with Disabilities*** for more information:

http://www13.shu.edu/offices/policies-procedures/employees-with-disabilities.cfm

Date: _____

Employee Name: _____

Dept.: _____ Job Title: _____

Work Phone: _____ Home/Cell Phone: _____

This section is to be completed by an Employee requesting a reasonable accommodation.

What limitation(s) is interfering with your job performance or accessing a benefit of employment?

_____

_____

What job function(s) are you unable to perform or what benefits of employment are you having difficulty accessing because of that limitation(s)?

_____

How does your limitation(s) interfere with your ability to perform your job function(s) or access a benefit of employment?

Describe any suggested accommodation(s) that you believe will assist you in addressing the above-referenced limitation(s):

Explain how that suggested accommodation(s) will assist you:

If applicable, identify the source and/or cost (if known) for providing the accommodation(s):

Employee/Requestor's Signature:

_____

Date: _____

Healthcare Provider Certification for

Reasonable Accommodation Interactive Process

Instructions:

This form is designed to facilitate the interactive process to explore reasonable accommodations under the Americans with Disabilities Amendment Act ("ADAAA"), and other related laws. Thank you in advance for your assistance.

Employee Name: _____

Healthcare Provider's Certification

Does the employee have a physical or mental impairment?

Yes _____ No _____

If yes, please identify the physical and/or mental impairment(s):

_____

_____

What is the expected duration of the impairment(s)?

_____

_____

Does the physical and/or mental impairment(s) substantially limit the employee's ability to perform a major life activity when compared to the average person in the general population?

Yes _____ No _____

If yes, please check all relevant major life activities:

Bending _____ Communicating _____ Eating _____ Reading _____

Speaking _____ Lifting _____ Performing Manual Tasks _____

Seeing _____ Standing _____ Hearing _____ Sitting _____

Thinking _____ Sleeping _____ Learning _____ Breathing _____

Caring for Oneself _____ Interacting with Others _____

Concentrating _____ Walking _____

Other _____

What essential job functions are impacted by the employee's physical and/or mental impairments?

_____

_____

Please indicate employee's job-related restrictions (check all that apply):

__ Lifting no more than ___ pounds.

__ Hours restriction (work no more than ___ hours per day or ___ hours per week).

__ No use of ___left ___right ___arm ___leg

__ Other (please describe)

_____

If applicable, please suggest workplace modifications, auxiliary aids or services that are necessary to enable the employee to perform the essential functions of the job.

_____

_____

I certify that the information provided is an accurate and complete representation of the patient's work reasons for said restrictions.

Healthcare Provider's Printed Name: _____

Healthcare Provider's Signature: _____

Date: _____

Healthcare Provider's Degree & License: _____

Healthcare Provider's Business Name & Address:

_____

_____

_____

RETURN THIS COMPLETED FORM TO:

DEPARTMENT OF HUMAN RESOURCES
Attn: Associate Vice President for Human Resources
366 South Orange Avenue
South Orange, NJ 07079
Fax: 973-761-9007
Email: michael.silvestro1@shu.edu

GINA DISCLAIMER

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 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.