Request for Reasonable Accommodation in Employment Instructions

To help process your request for a reasonable accommodation at work, please follow the instructions listed below. Medical information and records will be kept confidential by the College.

1. If you believe you need a reasonable accommodation in employment under federal, state, or local law, use this form to request an accommodation for a health condition.
2. Complete the “Request for Reasonable Accommodation in Employment Form.” Ensure that you have provided all requested information. Please sign and date the certification at the bottom of the form.
3. Complete and sign the Employee section of the “Physician Certification for Employee Accommodations” form and deliver the form to your doctor.
4. Request that your doctor fully complete the Provider section of the “Physician’s Certification for Employee Accommodations” form. ***This form must be signed by your doctor***. Responses to all information requested and your doctor’s signature are required before the form can be processed.
5. **Submit both** the “Request for Reasonable Accommodation in Employment” form and the “Physician’s Certification for Employee Accommodations” forms to Human Resources for processing.

*****Accommodation request forms are not needed for employees requesting an ergonomic chair or a sit-stand desk. Please confirm your supervisor’s approval, with a copy to HR for these ergonomic purchases*****

Please submit your packet in one of the following ways:

Email
humanresources@tacomacc.edu

Fax Number
253.566.5374

Interoffice Mailing Address
Human Resources
Building 14

External Mailing Address
Tacoma Community College
Human Resources, Bldg. 14
6501 S 19th Street
Tacoma WA 98466

Requests for a workplace accommodation will be promptly considered to determine if the request meets criteria established by law. You will receive an email from HR confirming the status of your request.

If needed, we may contact you to obtain additional information regarding your requested accommodation or any other accommodation. You may contact Human Resources at 253.566.5374 with questions.

TACOMA COMMUNITY COLLEGE

Request for Reasonable Accommodation in Employment

Employee Complete This Section

Date of Request			
Name			
Home Phone		Cell Phone	
Mailing Address			
Job Title			
Supervisor			
Department/Division			

What is the physical or mental condition for which you are requesting an accommodation?

When you were first diagnosed?

Is this need for accommodation temporary, permanent, or recurring? If temporary, how long do you expect to have the need for accommodation? If recurring, how often are recurrences expected?

How does this impact your ability to perform the essential functions of your regular job?
(You must be able to perform the essential functions of your job).

What, if any, reasonable accommodations are you requesting at this time?

Are you currently receiving any accommodations in the workplace? ☐ Yes ☐ No
If yes, please describe.

Check any of the following that you currently use:

☐Manual Wheelchair ☐Guide Animal ☐Hearing Aids
☐Powered Wheelchair ☐Crutches ☐Oxygen
☐Powered Scooter ☐Walker ☐Cane
☐Sight Assistive Devices *(other than eyeglasses or contacts)* ____
☐Other_____________________________________

Please check the appropriate box and describe the requested workplace accommodation.
☐Workstation/Equipment Accommodation ☐Environmental Accommodation ☐ Schedule Accommodation

How will this accommodation assist you in performing the essential functions of your job?

Certification
I certify that I have a condition that substantially limits one or more major life activities and for which I am requesting reasonable accommodation in the workplace as described above. I hereby authorize any licensed health care provider (including any hospital or any other medical service organization), any insurance company or any other institution or organization to release to the Tacoma Community College any medical information acquired. I further certify that all statements made in this form are true and correct, and realize that falsification or misrepresentation of this or any other documents may result in disciplinary action up to and including termination of employment.

Employee Signature **Date**

Print Name

TACOMA COMMUNITY COLLEGE

Physician's Certification for Employee Accommodations

Employee complete this section

Date	
Name	
Job Title	
Home Phone	
Cell Phone	

I hereby authorize the release to Tacoma Community College any medical information/records pertaining to my condition for processing my request for workplace accommodation. In addition, I understand and realize that falsification or misrepresentation of this or any other documents may result in disciplinary action up to and including termination.

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. 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.

I understand that my records are protected under Federal (42 CFR) and State (Health Care Information Act) Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Employee Signature ______________________________________ **Date:** ____________________________

TACOMA COMMUNITY COLLEGE

Doctor completes this section:

Your patient has requested a workplace accommodation based on their medical condition. The College will consider a request for workplace accommodation if the documentation received demonstrates that they have a condition covered under the federal, state, and local laws. A condition is a physical or mental impairment that substantially limits one or more major life activities. Examples of major life activities (MLAs) include but are not limited caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, sitting, reaching, interacting with others, and working. MLAs also include "major bodily functions," such as functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, circulatory, respiratory, endocrine, hemic, lymphatic, musculoskeletal, special sense organs and skin, genitourinary, and cardiovascular systems, and reproductive functions.

To determine eligibility for workplace accommodation we require current and specific documentation of the employee's condition from the diagnosing physician or health care provider. The information you provide is very important in allowing the College to make a proper determination related to this request. Please be as specific as possible in documenting the existence of a specific condition, including conditions which may fall into one of the categories of "**major body functions**" mentioned above.

All responses to the questions below should pertain to the medical conditions related to the condition(s).

Please do not provide any medical information other than the information requested to assess the scope of the condition and the need for the accommodation(s).

Failure to complete this form completely and legibly will result in a delay in consideration of your patient's request for accommodation.

Please respond to the following questions regarding your patient: ____________________________________(Name)

1. Description of condition(s) for which accommodation is requested:

☐ **Condition:** ____

Date of Onset: _________________ Expected End Date: ___________________

☐ **Condition:** ____

Date of Onset: _________________ Expected End Date: ___________________

2. Please specify the nature and severity of all physical or mental impairments (with and without medical treatment) that are related to the requested accommodation.

TACOMA COMMUNITY COLLEGE

3. Describe whether any symptoms related to the patient's condition (with and without medical treatment) cause **substantial** impairment in a major life activity.

4. List all restrictions required by your patient.

☐ No lifting, pushing, or pulling more than ______ lbs.
☐ No standing or walking more than ____ minutes per hour
☐ No kneeling more than ____ times per hour
☐ No squatting more than ____ times per hour
☐ No climbing more than ____ steps per hour
☐ Other (Specify) ____

☐ Restricted hours – Employee should work no more than ____________ hours per day

5. Are you aware of any job duties that your patient cannot perform? Please explain.

6. Does your patient require assistance in one or more major life activities because of their condition? Please explain:

7. Please list any devices such as a wheelchair, walker, cane, crutches, appliances, braces, etc. used by your patient:

8. Describe why the requested accommodation is necessary for the conditions(s) listed in question #1:

9. Is this patient a relative of yours? ☐Yes ☐No

If yes, please give relationship: ____

I, Dr. ______________________, declare that, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

Doctor Signature: ____ Date: _____________________

Print Provider Name: ____ Phone #:___________________

Medical Specialty: ____

Office Address: ____

Office Phone:_________________________ Office Fax:_________________ Office Email:_____________________

Please return this form and your response to Human Resources, 6501 S 19th Street, Tacoma WA 98466. To avoid delay, please feel free to electronically transmit your response to the following fax number: 253.566.5374 or via email to humanresources@tacomacc.edu.

If you have any questions, please do not hesitate to contact Mark Linder, at 253.566.5024 or Stephen Smith at 253.566.5055.