Reasonable Accommodation Form for Employees with Disabilities

Employees and applicants with disabilities should use this form to request a reasonable accommodation.

PLEASE **CLEARLY PRINT** OR **TYPE** – ATTACH EXTRA SHEETS IF NECESSARY

1. Name:_____

   Mailing Address:_____

   City:_____ State:_____ Zip Code:_____

   Home Phone:_____ Cell Phone:_____ Work Phone:_____

   Personal Email:_____ Work Email:_____

   Employee ID #:_____ Job Title:_____ Department:_____

   Manager/Supervisor:_____

   Is request for accommodation preventive or prescribed? ☐ Preventive ☐ Prescribed*

   *If prescribed, please fill out the Authorization to Use and Disclose Protected Health Information

2. What medical condition(s) limit your ability to do your job?[1]

3. Does your medical condition affect a major life activity (MLA)? If so, please explain which MLA are affected.

4. How long have you had your medical condition(s)? How long have you been treated for the condition(s)?

5. Please describe the accommodation(s) you request. Be as specific as possible.

6. What is the reason you need an accommodation(s)? What things are you unable to do without an accommodation? Be as specific as possible.

[1] 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 GINA. 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.

7. If you are requesting a type of equipment or a device, please describe the equipment/device. Do you know where the equipment can be obtained? What does it cost? Please provide this information if applicable.

8. Is there any other information that would help us evaluate your request?

9. Do you think you can perform the essential functions of your job with or without reasonable accommodation?

If you have a recent statement from your doctor stating your diagnosis, prognosis, any restrictions you may have with respect to your employment, and/or the projected duration of those restrictions, please attach it to this form. With your written consent, Blue Mountain Community College (BMCC) may request necessary medical information from your healthcare provider(s). **Your request for prescribed reasonable accommodation cannot be processed without information from your healthcare provider.**

Attached is a medical release authorizing BMCC to obtain medical information which is needed to evaluate a request for an accommodation under the Americans with Disabilities Act (ADA). I authorize my medical provider(s) to release such medical information, as indicated on the attached form, to BMCC's Human Resources department. A photocopy of the attached medical release shall have the same force and effect as the original.

Provider Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax Number: _____

Signature of Person Requesting Accommodation:

Name: _____ Date: _____

Hand deliver, email, fax, or mail this form to: Human Resources

Hand delivery location
Morrow Hall
M-1

Email: hr@bluecc.edu
Phone: (541) 278-5850
Confidential Fax: (541) 276-6523

Mailing address
Blue Mountain Community College
2411 NW Carden
Pendleton, OR 97801

Accommodation Approved: ☐ Yes ☐ No Reason for Denial: _____

_____

_____

_____ _____
Signature – HR Director Date

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize [*provider's name(s)*]_____to use and disclose a copy of the specific health information described below regarding [*employee/applicant's name*]_____, date of birth:_____, consisting of:

_____

_____

_____

to: Human Resources
Blue Mountain Community College
2411 NW Carden
Pendleton, OR 97801

for the purpose of:

_____

_____

_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS-related records*

_____ Mental health information*

_____ Drug/alcohol diagnosis, treatment or referral information**

** Must be initialed to be included in other documents.*
*** Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.*

This authorization does not cover, and the information to be disclosed should not contain, genetic information. "**Genetic information**" includes: Information about an individual's genetic tests; Information about genetic tests of an individual's family members; Information about the manifestation of a disease or disorder in an individual's family members (family medical history); An individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and Genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

This authorization is limited to the following treatment:

_____

This authorization is limited to medical treatment during the following time period:

_____

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, and treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the healthcare services are solely for the purposes of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to:

Human Resources
Blue Mountain Community College
2411 NW Carden
Pendleton, OR 97801
Fax: (541) 276-6523
Email: hr@bluecc.edu

SIGNATURE

I have read this authorization and I understand it.

Printed Name: _____ Expiration Date Medical Release*: _____

Signature: _____ Today's Date: _____

***** Unless otherwise indicated, this authorization expires one year from the date this release is signed.