

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

Request for New Accommodation	Request for Accommodation Extension Date	of Disability Onset:
Employee Name:	Employee Phoi	ne:
Employee Address:	Employee ID:	
Position Title:	Work Hours:ampm Work Days:	Dept.Name:
Workspace Location(Building, Floor, Suite	:Is this request due to a v	work-related injury? Yes No
Appropriate Dept. Administrator's N	ame: Dept. Administr	rator's Ext:
Primary Treating Physician Name:	Physician's Phone:	
	modification or adjustment to a job, the work env lified individual with a disability to enjoy an equal	•
Reasonable accommodations may in special equipment, workplace access a leave of absence to allow time for	s to assist an individual with performing the essent iclude but are not limited to: a modified/transition sibility modifications, shifting of non-essential dut recovery, therapy, training, or other disability-relation ill decide whether an accommodation can be provi	nal work schedule, provision of ies of the employee's position or ated needs. The Appropriate
I am requesting a reasonable accom-	nodation for the following reason: (Choose Only O	ne)
	and a reasonable accommodation is necessary in o to safely and effectively perform the essential func	
I am a current employee of CSU essential functions of my existi	DH and I am requesting a reasonable accommodating position.	tion in order to perform the
The state of the s	DH and I am applying for alternate position within ary to ensure I can safely and effectively perform t	_
	atment with a licensed healthcare provider? Yes nodation: Temporary or Permanent ?	No
2(b). If temporary, provide start	and end date for the accommodation: Start Date:	End Date:
3(a) Are your work limitations:	emporary or Permanent ?	
3(b) If temporary, provide start	and end date for the work limitations: Start Date:	End Date:
3(c). Provide Medical Limitation	s (Please do not disclose your diagnosis; explain yo	ur disability-related limitations and

how this accommodation will help you do your job. (example: no sitting for more than 2hrs per day; no walking; etc.)

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4. Accommodation(s) Requested (Be as specific as possible, for example adaptive equipment, Interpreter, training, schedule change, work location, etc.) The accommodation should assistance you with successfully performing the essential functions of your job:		
5. If you have additional information you would like to have considered please enter below:		
6. Have you requested FMLA, CFRA, PDL, or other leave in connection with the above described disability? Yes No		
If yes, please specify what you requested and when:		
7. Have you had any reasonable accommodations in the past for this same limitation(s) which were effective? Yes No If yes, please explain:		

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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 CSUDH Human Resources
- Faculty may request a copy of their position description from CSUDH 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. This is not an approval of the accommodation Request.	
Appropriate Dent 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 ADAmedicalaccommodations@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:

ADAmedicalaccommodations@csudh.edu.

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 furthe 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 upor 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:

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