

## REASONABLE ACCOMMODATION REQUEST FORM FOR EMPLOYEES AND APPLICANTS

\_\_\_\_\_ Date

Employee Name: \_\_\_\_\_ Employee Phone: \_\_\_\_\_

Employee Address: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Position Title: \_\_\_\_\_ Shift/Hours: \_\_\_\_\_ Department Name: \_\_\_\_\_

Workspace Location (Building, Floor, Suite): \_\_\_\_\_ Is this request due to a work-related injury? Yes  No

Appropriate Dept. Administrator's Name: \_\_\_\_\_ Manager's Phone: \_\_\_\_\_

Primary Treating Physician Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

**A “reasonable accommodation” is a modification or adjustment to a job, the work environment, or the way things usually are done, that enables a qualified individual with a disability to enjoy an equal employment opportunity.**

**The purpose of an accommodation is to assist an individual with performing the essential functions of their job. Reasonable accommodations may include but are not limited to: a modified/transitional work schedule, provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee’s position or a leave of absence to allow time for recovery, therapy, training, or other disability-related needs. However, the approved accommodation may differ from the preferred based on business need, essential job functions, and medical information/functional limitations.**

I am requesting a reasonable accommodation for the following reason:

\_\_\_\_\_ I am applying for employment and a reasonable accommodation is necessary in order to comply with your application procedures and/or to safely and effectively perform the essential functions of the desired position listed above.

\_\_\_\_\_ I am a current employee of CSUDH and I am requesting a reasonable accommodation in order to perform the essential functions of my existing position.

\_\_\_\_\_ I am a current employee of CSUDH and I am applying for alternate position within the organization. A reasonable accommodation may be necessary to ensure I can safely and effectively perform the essential functions of the position I am applying for.

1. Are you currently in active treatment with a healthcare professional?: Yes  No
2. Is your disability/serious health condition temporary  or permanent ? If temporary, what is the expected end date of the need for the accommodation? : \_\_\_\_\_
3. List the functional limitations (*physical or mental impairment that impacts one or more major life activities to the degree that the employee may request services or assistance in complete their essential job duties*) you are currently experiencing due to your disability/serious health condition:

4. Please list the specific essential job functions you are unable to perform due to your limitations:

5. Which part of your job do you need to modify? (List: job tasks, job hours, parking location etc.)

6. What suggestions for modifying your job do you have to ensure you have the ability to perform the essential function of your job?

7. Have you had any reasonable accommodations in the past for this same limitation(s) which were effective? If yes, please explain:

8. In the case of a building evacuation do you require emergency assistance to evacuate?:

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 Equity & Diversity 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.

\_\_\_\_\_  
Appropriate Dept. Administrator Name (Print)

\_\_\_\_\_  
Appropriate Dept. Administrator Signature & Date

**Questions please all WC/ADA Manager 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 facsimile to (310) 928-7154. 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/WC Manager  
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.

**MEDICAL RECORDS RELEASE AUTHORIZATION:**

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 to California State University, Dominguez Hills, or its agent, 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 further 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 upon 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 Fax to:

(310) 928-7154

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