m Reasonable Accommodation Request Form

Reasonable Accommodation Request Form

INFORMATION PERTAINING TO MEDICAL DOCUMENTATION:

In the context of assessing an accommodation request, medical documentation may be needed. Medical documentation is often needed to determine if the employee has a disability covered by the ADA and is entitled to an accommodation (i.e., has a permanent disability, as distinguished from temporary disability, that substantially limits one or more major life activities, affects the employee's ability to perform essential job functions, and is of sufficient severity) and if so, to help identify an effective accommodation.

Generally, in the context of an accommodation, medical inquiries related to an employee's disability and functional limitations are permissible and may include consultations with knowledgeable professional sources, such as doctors, occupational and physical therapists, rehabilitation specialists, and organizations with expertise in adaptations for specific disabilities. In the event that medical documentation is required, the *employee will be provided with the appropriate forms* to submit to their medical provider. The *employee has the responsibility* to ensure that the medical provider follows through on requests for medical information.
The City is committed to equal opportunity in all aspects of employment for qualified individuals with disabilities.

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CONFIDENTIAL
City of Baltimore
Reasonable Accommodation Request Form - Employment

The purpose of this form is to assist the City of Baltimore ("City") in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

Agency	Division/Unit

SECTION I: Employee: To be completed by employee requesting accommodation.

Employee:	Telephone:
Address:	
Job Title:	Request Date:
Supervisor:	Telephone:
Agency Human Resources Practioner:	Telephone:

I give the City of Baltimore permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act of 1990, as amended (ADA). I understand that all information obtained during this process will be maintained and used in accordance with ADA and all legal and regulatory requirements as they pertain to medical and genetic information confidentiality.

Date Employee's Signature

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Please answer the following questions to assist us in understanding the basis and nature of your request for a reasonable accommodation (attach additional sheets if necessary).

A. Indicate physical or mental limitation(s) and expected duration of limitation(s). (Attach additional pages if necessary.) It is not necessary to indicate a medical diagnosis or condition.

_____
_____
_____
_____
_____

B. Explain how the disability/limitation affects the ability to perform one or more essential functions of the job:

_____
_____
_____
_____
_____

C. What specific accommodation(s) are you requesting and how will this accommodation(s) assist you? (Attach additional pages if necessary):

_____
_____
_____
_____
_____
_____

D. Has a physician, vocational rehabilitation specialist, or other health professional recommended a specific accommodation? Yes ____; No ____;
If yes, please attach a copy of their recommendations.

E. Please provide any additional information that might be useful in processing your accommodation request:

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City of Baltimore
Request for Medical Information

Directions: Please print neatly or type requested information.
Employee's Name: _____

The above named employee has requested a change to their job because of a mental or physical condition. Please assist us by answering the following questions related to the employee's condition and need for an accommodation.

1. I (Medical Provider's Name)_____ _____ certify that (Name)_____ is being treated by my office for the condition described below:
   _____
   _____

2. Does the employee's condition prevent him/her from performing any of the essential duties, functions, physical requirements and/or activities listed on the attached Job Description and Functional Capacities Assessment form for the employee's position? If yes, please identify those duties, functions, physical requirements and/or activities that, in your opinion, the employee is unable to perform. (A completed Functional Capacities Assessment form and Job Description for the employee are attached to aid you in making this determination.)
   _____
   _____
   _____

3. For each duty, function, physical requirement and/or activity that you identify the employee is unable to perform, please state the medical reason that the employee is unable to perform those functions, duties and activities.
   _____
   _____
   _____

4. In your opinion, is the employee's medical condition temporary or permanent? If temporary, please state (if possible) the expected duration of the employee's inability to perform those functions, duties and activities identified above?
   _____
   _____
   _____

5. In your opinion, is the employee likely to experience injury, harm or aggravation of his/her medical condition by performing or attempting to perform the essential duties of his/her job? If so, to what degree? Please provide the medical basis for believing that this risk could occur.

   _____
   _____
   _____

6. Does the employee's medical condition present a significant risk of substantial harm to the employee and/or others?

   _____
   _____
   _____

7. Can the employee's condition be corrected and/or controlled through medication or treatment? If yes, explain?

   _____
   _____
   _____

8. Is the employee presently taking any medication, treatment, or other measures to correct and/or control his/her medical condition?

   _____
   _____
   _____

9. If yes, what effect, if any, does/would this medication, treatment or other measure have on the employee's ability to perform the essential duties of his/her job?

   _____
   _____
   _____

10. If you find that the employee has any condition:
    a. That will adversely affect his/her ability to perform the essential functions of his job (#2);
    b. That may be aggravated by his/her performance of or attempt to perform the essential duties of his/her job or that may lead to his/her injury or harm (#5); or
    c. That presents a significant risk of substantial harm to the employee and/or others (#6),

    please identify any accommodations which would enable the employee to perform the essential functions of his/her job without harm or injury to him/her, without aggravation of the impairment, or without presenting a significant risk of harm to the employee of others.

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_____
_____
_____

_____
Printed Name of Certifying Medical Provider

_____	_____
License number #	Type of Practice
_____	_____
Address	Telephone Number
_____	_____
Signature	Date