BUTLER UNIVERSITY

Reasonable Accommodation Request Form for Employees

All information regarding an individual's medical condition and the reasonable accommodation request is confidential and only disclosed to persons on a need-to-know basis. Any and all documents related to this request are kept confidential and will be maintained and used in accordance with applicable state and federal law.

Instructions: Individuals who are employed at Butler University and are requesting a reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act, relevant state law, and accompanying state and federal regulations, are encouraged to complete this form in its entirety.

In order to explore possible coverage and reasonable accommodations, information is required regarding your medical condition, essential job functions, applicable functional limitations and your requested accommodation(s).

It is often necessary for staff of the Benefits & Wellness team to discuss your medical condition and the documentation you submit to our office with providers such as licensed physicians, psychologists or other qualified professionals.

If you need help completing this form, someone else may complete it on your behalf, or you may contact the ADA Accommodations Case Manager at fmla@butler.edu or (317) 940-9355 for assistance.

Upon completion, please forward this form, along with the Medical Release Form, to fmla@butler.edu. Make sure you sign both forms.

☐ Faculty ☐ Employee/Staff ☐ Other (specify) ________________________

Name: ____
First Middle Last

Job Title: ____

Department: ____

Work Address: ____
City State ZIP Code

Work Telephone Number: ____

Work Email: ____

Home Address: ____
City State ZIP Code

Home Telephone Number: ____

Home Email: ____

Preferred method of contact: ☐ Home Phone ☐ Home Email ☐ Work Phone ☐ Work Email

How long have you worked/studied in current position? ________________________________

How long have you worked/studied at Butler? ________________________________

Supervisor's Name: ____
First Middle Last

Job Title: ____

Department: ____

Work Telephone Number: ____

Work Email: ____

Medical Information

Please identify the disability(s) for which you are requesting an accommodation.

Please provide the name and contact information for the health care professional who diagnosed and/or is overseeing your care for this condition. Please include the date of diagnosis.

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Job and Accommodation Information

Please explain how your medical condition(s) listed in Section B affect(s) your ability to perform the essential functions of your position. If you are a new employee, state the anticipated difficulties you foresee in completing your job duties. Be as specific regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

Please provide your specific request for a reasonable accommodation(s) and any information you may have about any associated costs (attach supporting documentation).

Are there any accommodations or assistive technologies you currently use?

Have you discussed this request for a reasonable accommodation with any other University employee (i.e. , co-worker, supervisor, HR, etc.)? Please include dates.

Please add any comments you feel may be helpful in consideration of your request.

Acknowledgement

I understand that it will be my responsibility to complete a Medical Release Form and provide it to the ADA Accommodations Case Manager for my request to be evaluated. I further understand that the ADA Accommodations Case Manager will evaluate and respond to me based upon the information that I provide.

________________________________ ____________________________

Signature Date

☐ Please check here if additional information is attached to this request.

Medical Inquiry Form in Response to an Accommodation Request

To be completed by a diagnosing Physician or Health/Mental Health Provider

Employee Name:	**Employee ID #:**
Job Title/Position:	**Phone:**

The individual listed above is an employee of the Butler University. The employee has requested a reasonable accommodation for a disability under the American's with Disabilities Act (ADA) and has identified you as the treating clinician. The employee believes a reasonable accommodation relating to their condition is necessary to enable them to perform the essential functions of their job. To assist Butler University in evaluating this request for accommodation, please answer the following questions. Please provide specific and detailed answers to these questions, using additional sheets where necessary. Enclosed is a copy of the employee's position description to assist you in completing this questionnaire. Some questions contain narratives and definitions, kindly review the narrative and/or definitions before answering the question. Butler University will use the information to evaluate the employee's request for accommodation in accordance with the ADA. The information you provide will be confidential.

A. Healthcare Provider Determination of Disability

Does the employee have a physical or mental condition that results in a disability? If YES, what is the impairment or the nature of the condition?	Yes ☐	No ☐
Is the condition permanent?	Yes ☐	No ☐
If the condition is NOT permanent, how long will it likely last? _________ # of Days, or __________ # of Weeks, or __________Years		
Is this a condition which may cause episodic rather than a continuing period of disability?	Yes ☐	No ☐
Is the patient taking medications that would be expected to affect job performance, or would pose a direct threat or safety risk? If yes, please explain:	Yes ☐	No ☐
Have you examined the employee for the condition in relation to their request for a reasonable accommodation?	Yes ☐	No ☐
If YES, please provide date(s) of examination:		

Answer the following question based on the limitations experienced by the employee when his or her condition is in an active state and the limitations the employee would experience if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit major life activities as compared to most people in the general population?	Yes ☐	No ☐

If yes, what major life activities or major bodily functions are affected?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Other: (describe)
☐ Breathing	☐ Interacting with Others	☐ Reading	☐ Standing	
☐ Caring For Self	☐ Learning	☐ Seeing	☐ Thinking	
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working	

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive	☐ Other: (describe)
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory	
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin	
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth		
☐ Circulatory	☐ Immune	☐ Operation of an Organ		

B. Physician's Statement in Determining Accommodation is Necessary

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

Essential Job Functions: What essential job functions will the employee be unable to perform without reasonable accommodation(s)?

Restrictions or Limitations: Describe the limitations or restrictions which prevent the employee from performing the essential functions of their job.

Please describe how the limitations defined above specifically interfere with the employee's performance of essential job functions.

C. Accommodation Options

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

Is the employee able to perform the essential functions of the employee's job with or without reasonable accommodation? Please indicate which functions can be performed with accommodations.	Yes ☐, with reasonable accommodation. Yes ☐, without reasonable accommodation.	No ☐, they are unable to perform their essential job functions with or without accommodation.

If NO, how long will the employee remain unable to perform the employee's essential job functions?

If YES, what adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of the employee's job?

If YES, how long will the employee need the proposed accommodations to perform the essential functions of the employee's job?

_______ # of Days, or ________ # of Weeks, or ☐ Permanently

Medical Provider Signature	**Date**
Medical Provider Name **(please print)**	**Office Phone Number**
License #	**State**
Address	**Zip**

Please return this form (and any additional information or attachments) to the employee, or upon employee request, please fax it directly to Butler University Human Resources at 317-940-9355 or mail it to Butler University, Benefits Office at 4600 Sunset Ave., Indianapolis, IN 46208.

Other comments: