

**SAN DIEGO STATE UNIVERSITY
OFFICE OF EMPLOYEE RELATIONS & COMPLIANCE
ASSISTIVE DEVICE/AUXILIARY AID PROGRAM**

APPLICATION FOR FUNDING

The Assistive Device/Auxiliary Aid Program is intended to provide a financial resource to departments in providing reasonable accommodation to employees with disabilities. Reasonable accommodation is to be determined by SDSU following its receipt of an individual's request for accommodation and engagement in an interactive process with the individual to identify the nature and extent of the limitations and an effective accommodation.

(PLEASE PRINT OR TYPE)

1. Name of Employee Requesting Funds: _____
2. Job Classification: _____
3. Job Title: _____
4. Department Name/ Employee's Phone Number: _____ / _____
5. Position: _____ Faculty _____ Staff _____ Manager (MPP) _____ Student employee
6. Please explain how your condition limits the performance of job functions/tasks and how this assistive device/auxiliary assistance will help you perform the essential functions of your job.

MEDICAL VERIFICATION REQUIRED

1. Unless the disability or need for accommodation is obvious or otherwise already known to the decision maker, medical verification is necessary. Has the need for accommodation been verified by completion of the medical verification form by an appropriate medical professional?
_____ Yes _____ No (medical verification should not include a diagnosis)

If no medical verification is provided, please explain why not:

**REQUEST FOR ASSISTIVE DEVICE
OR EQUIPMENT**

Equipment and devices purchased using Program funds remain the property of SDSU, on loan to the department and assigned to a specific employee. In the event that an employee is transferred or reassigned to another department within SDSU, the equipment purchased on behalf of that employee may continue to be used by the employee as long as the need for the equipment continues. If the recipient employee is separated from SDSU or, if for any other reason, the employee no longer needs the purchased equipment, the equipment must be returned to the Office of Employee Relations & Compliance.

1. Specify vendor and costs as accurately as possible. List components and prices separately. Attach all documentation to form.

2. Amount requested to purchase Assistive Device: \$ _____

Signature of Requestor: I understand that, maintenance and replacement of lost, damaged, or destroyed equipment purchased using these funds, is my responsibility.

Signature

Date

Department Approval: I understand that equipment purchased using these funds remains the property of the Assistive Device/Auxiliary Assistance Program and must be returned to the Office of Employee Relations & Compliance upon the recipient employee's separation from SDSU.

Signature of Chair or Dept Head

Title

Date

Signature of Dean or Other Appropriate Administrator

Title

Date

**SAN DIEGO STATE UNIVERSITY
MEDICAL VERIFICATION**

Employee's Name _____ DOB _____

I give my permission for a licensed health care professional who is familiar with my condition to provide the documentation necessary to establish that I have a disability that may qualify me for a reasonable accommodation.

Employee Signature _____ Date: _____

The above named employee has requested an accommodation in the form of _____
_____.

In order to determine whether this individual has a covered disability as defined by the Americans with Disabilities Act of 1990 and the Fair Employment and Housing Act (California Government Code § 12925 –12928), this office requires certain information that only a qualified, licensed professional can provide. Please take a moment to complete this form as fully as possible. If you have questions or concerns, please contact SDSU's Office of Employee Relations & Compliance by phone at (619) 594-8640.

Please check the definition that fits this individual.

An employee fits the definition of disabled under the federal and state disability laws if he or she

- has a mental or physical impairment that limits or makes difficult one or more major life activities;
- has a history of such an impairment; or
- is regarded or treated as having or having had such an impairment or such an impairment that currently has no disabling effects, but may become a qualifying impairment in the future.

Please check the major life activities that are made difficult by this individual's impairment.

- | | | | | |
|-----------------------------------|------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Learning | <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> Interacting with others |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Hearing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Standing | <input type="checkbox"/> Other (please describe) _____ |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Breathing | <input type="checkbox"/> Thinking | <input type="checkbox"/> Caring for oneself | |
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Reaching | <input type="checkbox"/> Working | <input type="checkbox"/> Concentrating | |

Is the accommodation being requested necessitated by this individual's impairment? ____ yes ____ no
and consistent with the affected major life activity? ____ yes ____ no

What is the expected duration of this individual's impairment? _____

Licensed Health Care Professional's Signature Date

Licensed Health Care Professional's Name (please print) Specialty

Address City, State & Zip

State License # Phone #

Please return the completed form to: **Office of Employee Relations & Compliance, San Diego State University, 5500 Campanile Drive, San Diego, CA 92182-1695** or fax to **(619) 594-1881**.