San Diego State University
Office of Employee Relations & Compliance

REQUEST FOR REASONABLE ACCOMMODATION

EMPLOYEE REQUEST

Employee Name _____

Working Title _____ Classification_____

Phone _____ Department_____

Supervisor _____ Title_____

Phone _____ Fax _____

1. I am requesting an accommodation for the following reason:

__ I am applying for employment and a reasonable accommodation is necessary in order to comply with your application procedures.

__ I am currently employed by SDSU and am requesting a reasonable accommodation in order to perform the essential functions of my existing position.

2. Summarize the primary job responsibilities and attach a current copy of the position description in which you are currently employed or for the position that you are interested in apply for. (Please contact The Center for Human Resources, if you need a copy of a position description.)

_____

_____

_____

3. Describe the essential functions of the position for which assistance is being requested. (e.g. reading, writing, driving, lifting, typing)

_____

_____

_____

_____

_____

4. Describe any accommodations which you believe are necessary to allow you to effectively perform the essential functions of the position.

_____

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_____

5. If accommodation is time sensitive, please explain:

_____

I certify that the information provided above is true and correct to the best of my knowledge.

_____ _____

Employee Signature Date

Fill out and sign the Authorization for Release of Medical Information found on the next page.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of medical information regarding the limitations I have described in the attached Request for Reasonable Accommodations form. This authorization is limited to the details provided below:

1. Name, address and telephone number of treating physician authorized to release information:
   _____
   _____

2. This information will only be released to those persons who have a business need to know in order to evaluate this request.

3. I authorize the release of any medical information necessary to evaluate my ability to perform the essential functions of the job in question.

4. This information shall be used solely for the purpose of determining reasonable accommodations for my disability.

5. This authorization shall remain valid for as long as the need for an accommodation remains necessary.

I understand that I have the right to receive a true copy of this authorization. By my signature at the bottom of the original authorization, I hereby acknowledge that I have received a true copy of this authorization.

Employee Signature: _____ Date:_____

SUPERVISOR'S REVIEW

1. Identify the essential and non-essential functions of the position and analyze the job requirements after consulting with employee/applicant and reviewing functional limitations.

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_____

_____

_____

_____

2. Identify position related limitations.

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_____

3. Identify possible reasonable accommodation.

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_____

4. Assess whether the proposed accommodation poses an undue hardship.

_____

_____

_____

_____

5. Do you concur with the statements made by the employee and/or do you want to add any additional information?

_____

_____

_____

_____

_____ _____

Supervisor's Signature Date

_____

Title

DEAN/DIRECTOR

1. Do you concur with the statements made by the employee and/or do you want to add any additional information?

_____

_____

_____

_____

_____ _____

Dean/Director Signature Date

MEDICAL REVIEW

(to be completed by employee's physician)

Please refer to the employee's Authorization for Release of Medical Information found on the last page prior to responding.

Employee is currently able to perform all job functions described in the attached job description without posing a direct threat to the safety of self or others

☐ Yes ☐ No

If no, employee has the following limitations in relations to described job functions.

Functional Limitation:

(Please be specific as to each limitation and its expected duration)[1]

_____

_____

_____

_____

_____ _____

Physician's Signature Date

[1] **NOTICE:** 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 sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

FINAL ACTION

Accommodation approved? ☐ Yes ☐ No

If yes, describe accommodation and duration:

_____

_____

_____

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_____

_____

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_____

If no, explain: _____

_____

_____

_____

_____

_____ _____

Supervisor's Signature Date

_____ _____

Dean/Director Date