REASONABLE ACCOMMODATION REQUEST

Please complete this form if you have a physical or mental health disability and need a reasonable accommodation to perform the essential functions of your position or to participate in the hiring process. Should you need any help completing this form, or if you have any questions about this form or the Ohio Department of Higher Education's reasonable accommodation policy, please contact Drew White, Human Resources Director/ADA Coordinator at dwhite@highered.ohio.gov or 614-292-2318. This form should be returned directly to the Ohio Department of Higher Education, 25 S. Front St., 7th Floor, Columbus, Ohio 43215, Attention: Drew White, Human Resources Director/ADA Coordinator. FOR CURRENT EMPLOYEES, THIS FORM SHOULD NOT BE RETURNED TO YOUR MANAGER OR TO ANYONE ELSE AT THE OHIO DEPARTMENT OF HIGHER EDUCATION AS IT MAY CONTAIN CONFIDENTIAL MEDICAL INFORMATION.

EMPLOYEE/APPLICANT NAME:

STATE OF OHIO EMPLOYEE IDENTIFICATION NUMBER (if applicable):

CURRENT TITLE OR APPLICATION TITLE:

1. Please describe the accommodation(s) you are requesting. If there is more than one accommodation that you believe will meet your needs, please describe all possible accommodations.

2. Please describe your medical condition and the reason(s) why you are requesting an accommodation. For current employees, include a description of the essential functions of your job that you currently are unable to perform, and explain how the requested accommodation(s) will enable you to perform those essential functions of your job.

EMPLOYEE/APPLICANT NAME:

3. Estimated length of time requested reasonable accommodation(s) will be needed.

4. Please provide/attach any documentation that you believe supports your need for the requested reasonable accommodation as well as any other information that you believe is relevant to your request.

I certify that the information contained in and attached to this form is true and correct.

Signature: Date:

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CERTIFICATION OF HEALTH CARE PROVIDER FOR REASONABLE ACCOMMODATION

Patient/Employee Name:

Date Condition Commenced:

Probable Duration of Condition:

This certification will be used for the purpose of assessing whether your patient has a disability that would benefit from a reasonable accommodation within the workplace. Please base your assessment on your patient's present abilities or limitations in performing the essential functions of their current position as described to you.

1. Does your patient have a disability?[1] ☐ Yes ☐ No

2. If you answered "yes" to question #1, is your patient able to perform each of the essential job functions described **without** reasonable accommodation(s)? ☐ Yes ☐ No

3. If you answered "no" to question #2, would your patient be able to perform each of the essential job functions described **with** reasonable accommodation(s)? ☐ Yes ☐ No

4. If you answered "yes" to question #3, please provide the following information: a) state which essential function(s) of the job require an accommodation; b) for each such essential function, any recommendations you have for reasonable accommodation(s). If there is more than one recommended accommodation, please describe all possible accommodations; c) explain why the disability requires this accommodation to allow the employee to perform the essential function(s).

[1] A disability is a condition that imposes a substantial limitation on a major life activity. By way of example, "major life activities" include, but are not limited to, standing, sitting, walking, lifting, talking, interacting with others, eating, breathing, hearing, seeing, speaking, working and learning. Disability also means a physical disability, infirmity, malformation or disfigurement which is caused by bodily injury, birth defect or illness including epilepsy and other seizure disorders, and which shall include, but not be limited to, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment or physical reliance on a service or guide dog, wheelchair, or other remedial appliance or device, or any mental, psychological or developmental disability resulting from anatomical, psychological, physiological or neurological conditions which prevents the normal exercise of any bodily or mental functions or is demonstrable, medically or psychologically, by accepted clinical or laboratory diagnostic techniques.

Patient/Employee Name:

Print or type clearly the name and address of the Health Care Provider completing this form:

Name:

Address:

Telephone:

E-mail Address:

_____ _____

Signature of Health Care Provider Date

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