Human Resources Department
16000 N. Civic Center Plaza
Surprise, AZ 85374
Office: 623-222-3500
Confidential Medical Fax: 623-222-3504
TTY: 623-222-1022

EMPLOYEE REQUEST FOR ACCOMMODATION

Please note that this information will be maintained in a separate, confidential file from your personnel file and will be shared with supervisors/managers only on a need to know basis.

Employee Name:_____ Department:_____

Job Title:_____ Supervisor:_____

Work phone:_____ Home phone:_____

1. Is your accommodation request time sensitive? ☐ Yes ☐ No
   If *yes*, please explain _____

2. What limitation is interfering with your ability to perform the essential functions of your job or access an employment benefit?

   _____

   _____

   _____

   _____

3. Is the limitation temporary? ☐ Yes ☐ No
   Please state the expected duration:
   From_____to _____(date) or Indefinite ☐ Always ☐

4. What accommodation are you requesting?

   _____

   _____

   _____

   _____

5. Explain how the accommodation will enable performance of essential functions of position: _____

_____

_____

6. Have you had any workplace accommodations in the past for this same limitation?

   If yes, please describe: _____

   _____

   _____

7. How have you managed these limitations outside of work?

   _____

   _____

8. Please provide any additional information that might be useful in considering your accommodation request.

   _____

   _____

It is the policy of the City of Surprise to provide reasonable accommodations to qualified individuals with disabilities in accordance with the Americans with Disabilities Act Amendments Act of 2008, 42 U.S.C. § 12101 and City of Surprise Anti-Discrimination/ Accommodation Policy 3.1. I understand that a successful interactive process will typically depend on my:

- Timely and detailed responses regarding limitations and suggested accommodations
- Providing requested medical updates and/or clarification from my treating physician(s)
- Reporting any changes in my disability status or accommodation needs
- Submission of additional request(s) in the event of a change in job position, essential tasks or location

I agree to cooperate fully in this process. I understand that my specific requests may not be granted however the City will attempt to provide a reasonable accommodation that does not create an undue hardship on the City's business. Any accommodations provided as a result of this request do not signify approval of future reasonable accommodation requests.

Employee's Signature:_____ **Date:**_____

RETURN COMPLETED FORM TO:

Human Resources Department
Attn: Chanda Washington
16000 N. Civic Center Plaza Surprise, AZ 85374
Phone: 623-222-3542
Confidential Medical Fax: 623-222-3504
chanda.washington@surprizeaz.gov

Human Resources Department
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TTY: 623-222-1022

MEDICAL AUTHORIZATION AND RELEASE

Employee Name: _____ Department: _____

Job Title: _____ Supervisor: _____

Work phone: _____ Home phone: _____

Pursuant to my request for reasonable accommodation under the Americans with Disabilities Act, I hereby authorize the release and disclosure of medical information related to my request for reasonable accommodation to the authorized representative of the City of Surprise Human Resources Department bearing this release or a photocopy thereof, in order to evaluate my request for reasonable accommodation.

The types of medical information or documentation that may be released may include the past, present, and expected future nature, severity and duration of the impairment (*e.g.*, functional limitations, symptoms, side effects of any treatments, etc.), the activities the impairment limits; the extent of the limitations; and why the individual requires reasonable accommodation or the particular reasonable accommodation requested, and how the reasonable accommodation will assist the individual to apply for a job, perform the essential functions of the job, or enjoy a benefit of the workplace.

GINA 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.

This authorization to release medical information will expire six (6) months after the date signed. I have the right to request and receive a copy of this authorization.

Disclosing Agencies:

Physician Name: _____ Phone: _____

Address: _____

Physician Name: _____ Phone: _____

Address: _____

Employee Signature: _____ **Date:** _____

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ADA- REQUEST FOR INFORMATION FROM HEALTHCARE PROVIDER

Your patient_____who is employed as a_____for the City of Surprise has requested your assistance in providing information related to their request for a reasonable accommodation under the Americans with Disabilities Act. Please provide the requested information only – **please do not send copies of medical records.** Your evaluation should be based on your understanding of a particular position's Essential Job Functions (attached) and your patient's ability to perform those functions.

GINA 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.

The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities. Examples of major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and the operation of a major bodily function such as the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive systems.

1. Which Essential Job Function(s) is the employee substantially limited in performing?

   _____

   _____

   _____

2. Please describe the functional limitations:_____

   _____

   _____

3. Are the limitations temporary? ☐ Yes ☐ No

   Please state the expected duration:

   From_____to_____(date) or Indefinite ☐ Always ☐

4. What accommodations are you suggesting? _____

5. Explain how this accommodation would enable performance of the essential functions: _____

6. If employee is currently off from work, anticipated date you expect the employee to return.

   Date_____ Indefinite ☐ Never ☐

   If indefinite or never, is there another type of job this employee could return to?

   ☐ Yes ☐ No Please explain: _____

   How many hours per day and per week can the employee work? _____

7. Would a leave of absence from the employee's job assist the employee in being able to return and perform the essential functions of the jobs with or without further accommodations? ☐ Yes ☐ No
   If so, approximately how long of a leave of absence would the employee need? _____

8. Do you believe the employee poses a direct threat to the health or safety of self or others?
   ❒ Yes ❒ No (If yes, please explain)

9. Please provide any additional information that might be useful in considering the accommodation request.

_____ _____

Healthcare Provider's Signature **Date**

_____ _____

Printed Name **Phone**

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