Americans with Disabilities Act (ADA)
Request for Reasonable Accommodation Form

INSTRUCTIONS

Employees should work with their Healthcare Providers to complete this Request for Reasonable Accommodation Form. Consistent with the requirements of the Americans with Disabilities Act (ADA), RISD will provide reasonable accommodations to a qualified individual with a disability who has made RISD aware of their disability, provided that such accommodation does not constitute an undue hardship and enables the employee to perform the essential functions of their job. Employees who wish to request reasonable accommodation should provide a copy of their current job description to their health care provider, who should review Section II and complete Section III of this form.

GINA COMPLIANCE NOTIFICATION: Please note that 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 individuals or their family members. **To comply with this law, we are asking you not to provide any genetic information when responding to this request for medical information.** "Genetic information" that should not be disclosed pursuant to 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, genetic information of a fetus carried by an individual or an individual's family member, and genetic information of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

The information sought on this form should pertain only to the condition for which the employee is requesting an accommodation under the ADA. Contents of this request are confidential and will only be shared as needed with the appropriate personnel to consider the implementation of a reasonable accommodation. All medical documentation will be kept confidential.

The completed form is to be returned to: Human Resources, Attn: Benefit Partner, 20 Washington Place, Providence, RI 02903 or faxed to: (401) 454-6565 or by email to benefits@risd.edu. For questions, please call (401) 454-6428.

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SECTION I: TO BE COMPLETED BY THE RHODE ISLAND SCHOOL OF DESIGN (RISD) EMPLOYEE

RISD ID#: ____________________

Employee Name: ____

Job Title: ____

Department ____

Supervisor: ____

Employee's preferred contact information:

Phone Number: ____

Email Address: ____

Release of Information

I hereby authorize my healthcare provider to complete this form and release the following information to RISD's Human Resources Office for the purpose of determining the availability of reasonable workplace accommodations. I further authorize RISD to seek clarification of this documentation if necessary, by contacting my health care provider. I hereby acknowledge and understand that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

_______________________________________ ___________________________

Employee Signature Date

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SECTION II: INSTRUCTIONS FOR THE HEALTH CARE PROVIDER

RISD complies with the Americans with Disabilities Act (ADA). Under the ADA, except where it would cause the college an undue hardship, RISD will provide reasonable accommodations to disabled employees so that they can enjoy equal employment opportunities. Generally, so that RISD can weigh an employee's request for a reasonable accommodation, the first step is determining whether the employee has a disability that is covered by the ADA.

To this end, and in response to the employee's request for a reasonable accommodation, RISD is requesting you to provide a certification to the Human Resources Department that includes the following:

1. A description of the nature, severity, and duration of the employee's condition, the activity or activities that the condition impacts, and the extent to which the condition impacts the employee's ability to perform the activity or activities; and

2. An explanation of why the requested reasonable accommodation is necessary.

Documentation is insufficient if it does not specify the existence of an ADA disability and explain the need for reasonable accommodation. Documentation also might be insufficient where the information does not specify the functional impacts due to the disability.

The employee has been instructed to provide you with a copy of their job description containing information about their essential job functions and working conditions. Please review this information as you consider what the employee's impacts may be and possible accommodations to alleviate them. If you were not provided a copy of the job description, please ask the employee to provide it to you prior to completing to this form.

If you have any questions regarding this request for information, please feel free to contact the RISD Human Resources department at (401) 454-6428. We appreciate your assistance in this matter.

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SECTION III: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

1. Does the patient currently have a physical or mental condition? ☐ Yes ☐ No

2. Does the condition substantially impact a major life activity(s) which in turn impacts the employee's ability to perform the essential functions of their job? ☐ Yes ☐ No

   If yes, please describe the major life activity(s) affected by the condition.

3. How does this condition impact the patient's activities when it is active? Please include any impacts resulting from medication or treatment for the condition. **Note to California Health Care Providers. Do not answer this question.**

4. How would you describe the duration of this condition?

   ☐ Permanent ☐ Long-term (greater than 1 year but not permanent)
   ☐ Short-term (less than 1 year) ☐ Intermittent

   If impacts of the condition are intermittent, please indicate the anticipated frequency and duration.

   Frequency: _____ times per _____ ☐week(s) / ☐ month(s)

   Duration: _____ hours or ___ day(s) per episode

5. Is the employee able to continue working with reasonable accommodation while experiencing impacts due to their condition? ☐ Yes *(please proceed to question 6)* ☐ No *(please skip to question 7)*

6. If the answer to #5 is Yes, what part(s) of the employee's essential job functions are impacted by the condition?

   What accommodations may alleviate or mitigate the patient's impacts with respect to their essential job functions?

   How long do you anticipate these accommodations would need to be in place?

7. If the answer to #5 is No, is the suggested accommodation that the employee take a leave of absence?
   ☐ Yes ☐ No

   What is the medical necessity for the leave of absence?

How will the leave allow the employee to return to performing the essential functions of the job if approved?

For a continuous leave of absence request, how much leave will the employee need to take and what are the approximate dates?

Length: _____ ☐week(s) / ☐ month(s)

Anticipated Start Date: _______________ Anticipated Return Date: _______________

For an intermittent leave request, what is the expected frequency and duration of absences?

Frequency: _____ times per _____ ☐week(s) / ☐ month(s)

Duration: _____ hour(s) or ___ day(s) per episode

Can these absences be scheduled in advance? If not, why?

8. Will the employee be able return to work, with or without reasonable accommodation, at the end of the leave of absence? ☐ Yes ☐ No

   If no, when do you expect the employee to be able to return to work?

   ☐ By the following date: _________________ ☐ Unknown at this time

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SECTION IV: HEALTH CARE PROVIDER SIGNATURE AND CONTACT INFORMATION

Name: ____

Medical Practice & Address: ____

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Telephone: ______________________________ Fax: _______________________________

Signature: _______________________________ Date: _____________________________