Confidential
State University of New York at Oswego

Reasonable Accommodation Request Form

The purpose of this form is to assist the College in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. This form must be filed separately from the employee's personnel file and be treated confidentially.

Section I:
To be completed by the employee requesting accommodation.

Employee:_____

Job Title: _____ **Request Date:**_____

Department: _____

I give the State University of New York College at Oswego permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act and the New York Human Rights Law. I understand that all information obtained during this process will be maintained and used in accordance with confidentiality requirements of those statutes.

I further understand that I may be required to complete and sign the attached release of information, giving SUNY Oswego permission to consult with my health care professional(s) in order to determine that I am a qualified employee with a disability and potential accommodations.

_____ _____

Employee Signature **Date**

_____

Employee Name (please print)

Please answer the following questions to assist us in understanding the basis and nature of your request for an accommodation (attach additional sheets if necessary).

A. What are the limitations caused by your condition(s) that you are currently experiencing?

   Identify the essential functions affected and be specific about how the medical condition impairs your ability in each instance.

B. Given your limitations, what parts of your assigned job duties (essential functions) are impeded by your condition?

C. Explain how the accommodation(s) you are requesting will enable you to perform the essential functions of your job.

D. Will you be able to perform all the essential functions of your job if you receive the requested accommodations?
   If not, describe the functions you will not be able to perform.

E. Do you need assistance to identify accommodations that will enable you to perform the essential functions of your job?
   If you do, please explain the type of assistance you will need.

F. Provide any information or suggestion you can as to how the requested accommodation(s) can be provided. If known, please include the names, addresses and telephone numbers of vendors and model number and approximate cost of any equipment requested.

AUTHORIZATION FOR HEALTH CARE/HEALTH INSURANCE RELEASE OF INFORMATION

Information about you and your health is personal and the State University of New York (SUNY) at Oswego is committed to protecting the privacy of such information. In addition, your personal health information (PHI) is, in many cases, protected from use and disclosure by both State and Federal law. As a result, SUNY Oswego will not use your PHI to advocate on your behalf with respect to health care or health insurance matters unless you sign this form permitting SUNY Oswego to use your PHI for this purpose. Please carefully read this form and the information set forth below before signing. If you have any questions regarding what is set forth on this document, please contact the State University Privacy Officer at privacy@sunyadm.suny.edu.

Patient Name:_____ Last four of Social Security #:_____

Address:_____

Date of Birth: _____ Telephone #:_____

I hereby authorize the specified representative(s) of SUNY Oswego to release and/or obtain information related to my medical care for the specified date(s) or type(s) of services to the specified insurer(s) and/or provider(s):

Name of Designated SUNY Oswego Representative: _____Holly DeMar_____

Date(s) and/or Type(s) of Service:

☐ Health care for or on the following date(s) only: _____
☐ All health care provided
☐ Health care for specified condition/treatment: _____

Provider(s):

☐ All health care providers (including physicians and hospitals)
☐ Health care from the following provider(s) only:

_____
Please specify individual provider(s)

Insurer(s):

☐ The specified health care insurer(s) and/or HMO's:_____
Please specify individual insurer(s)

By providing this authorization, I give permission for the representatives of SUNY Oswego to discuss the medical care that I received from the above providers, during the time period listed, as well as the actual or requested payment for such care, with both the providers and insurers listed above. I understand that I can rescind this authorization at any time thereby affecting future (but not past) communications. If not earlier rescinded by me, this authorization shall expire on _____.
Please specify date

_____
Print name of patient (or personal representative)

_____ _____
Signature of patient (or personal representative) Date

Section II:
To be completed by Human Resources

1. Send a copy of the following to the health care professional(s) where applicable:
    a. The signed Health Care Professional Release Form

2. After receiving documentation from the health care professional(s) answer the following:

Has a health care professional documented that the employee has a physical or mental impairment that substantially limits the employee's ability to perform the essential job functions?

Yes_____ No_____ Other_____

If yes, or other,

Recommendations: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Health Care Provider Information
For
Reasonable Accommodation Request

_____ (Employee's name) holding the position of _____ (position title) has indicated that he/she has the following impairment(s):

Please answer the following questions regarding the employee's condition as it relates to the essential functions and possible accommodations. The employee's signed release is also attached.

1. Does the impairment (impairments) substantially limit a major life activity?
   If so, please describe the impairment(s) and the limitations.

2. Does the employee use (or can the employee use) any mitigating measures (medications, assistive technologies, etc) to limit the impact of the impairment on major life activities?
   How do the mitigating measures affect the impairment and the limitations on major life activities?

3. Does the impairment (or impairments) affect the employee's ability to perform the essential functions of the position as you understand them?

4. If the employee is unable to perform one or more of the essential functions of the employees' job, are there any accommodations that, in your opinion, would allow the employee to perform the essential functions of the job?
   If so, please describe those accommodations?

5. Is the need for accommodation(s) likely to be temporary or permanent?
   If temporary, how long do you estimate the need for accommodation will exist?

Provider Name (print) **Provider (Signature)**

Type of Practice or Specialty

Phone Number **Fax Number**

Email

Date

Please return completed form to:

Holly DeMar
SUNY Oswego
Office of Human Resources
7060 Route 104
201 Culkin Hall
Oswego, NY 13126
Ph: 315-312-2230
Fax: 315-312-6333
hr@oswego.edu