Request Form: Reasonable Accommodation for Applicants and Employees with Disabilities

Employees and applicants should use this form to request reasonable accommodations needed due to a medical condition that may qualify as a disability.

FORM INSTRUCTIONS

Print or type the requested information on the following pages.
Leave blank if not applicable or the answer is not known.

Submit your form to the OHSU Office of Civil Rights Investigations and Compliance Department (OCIC) via email, confidential fax, hand delivery, or U.S. Mail.
Please call OCIC with questions: 503 49**4-5148**.

Email: ocic@ohsu.edu
Fax: 503 346-8037
U.S. Mail: OCIC
Oregon Health & Science University
Mail code PP244B
3181 SW Sam Jackson Park Road
Portland, OR 97239

WHAT YOU NEED TO KNOW

The information you provide to OCIC may be shared with others on a *need-to-know* basis. People who may need to know to include relevant supervisors, Human Resources, and others as needed to achieve the disability interactive process.

Employees and applicants have a right to be free from unlawful discrimination, harassment, or retaliation due to mental and physical impairments that qualify as disabilities. You also have a right to request reasonable accommodation and OHSU will explore options with you, as appropriate.

If you have concerns about discrimination, harassment, or retaliation, please contact OCIC by phone (503 49**4-5148**) or email (ocic@ohsu.edu).

ADDITIONAL RESOURCES

You may be eligible to take leave for medical or family reasons under the Family and Medical Leave Act (FMLA) and/or the Oregon Family Leave Act (OFLA). To request family and medical leave, please call The Standard at 1-800-378-2390. The Standard is OHSU's leave administrator and phone lines are open all day, every day.

If you miss work due to a disability and have short-term (STD) or long-term disability (LTD) insurance coverage, you should call The Standard (1-800-378-2390) about filing a claim.

You may have questions about employee benefits. Please contact the Benefits Department so they can assist you: benefits@ohsu.edu or 503 49**4-7617**.

You can also contact OCIC to request reasonable accommodation needed due to pregnancy, childbirth, and related medical conditions.

Request Form: Reasonable Accommodation for Applicants and Employees with Disabilities

Employees and applicants should use this form to request reasonable accommodations needed due to medical conditions that may qualify as a disability.

Please **PRINT CLEARLY** or **TYPE**, and attach extra documents if needed.

Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Pronoun(s):_____ Preferred Phone:_____

Preferred Email:_____ Preferred Method of Contact: _____

Employee ID #:_____ Job Title:_____

Manager/Supervisor:_____

Department: _____ Shift Hours:_____

Days Off (please check all that apply): ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su ☐ Rotating

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1. What medical condition(s) limit your ability to do your job?[1]

2. How long have you had your medical condition(s)? How long have you been treated for the condition(s)?

3. What things or activities are you unable to do as a result of your medical condition?

[1] 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 GINA. 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.

4. Please describe the accommodations you request, including if equipment is needed. Be as specific as possible.

5. What is the reason you need an accommodation(s)? What work tasks, duties, or functions are you unable to do without an accommodation? Be as specific as possible.

6. Do you think you can perform the essential functions of your job with or without reasonable accommodation?

7. Is there any other information that would help us evaluate your request?

If you have a recent statement from your healthcare provider with diagnosis, prognosis, workplace restrictions, or duration for restrictions, please provide that with this form.

With your written consent, Oregon Health & Science University (OHSU) may request necessary medical information from your healthcare provider(s). **Information from your healthcare provider may be necessary to process your request for reasonable accommodation**. **OCIC will only share medical information on a need-to-know basis and people OCIC might deem as needing to know include (but are not limited to) relevant supervisors, Human Resources, and the Legal Department.**

Attached is a medical release authorizing OHSU to obtain medical information which is needed to evaluate a request for accommodation under state law and the Americans with Disabilities Act (ADA). I authorize my medical provider(s) to release such medical information, as indicated on the attached form to OHSU's Office of Civil Rights Investigations and Compliance (OCIC) Department. A photocopy of the attached medical release shall have the same force and effect as the original.

Provider Name(s):_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Provider Phone:_____ Fax Number:_____

Signature of Person Requesting Accommodation:

Name: _____ Date: _____

AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

I authorize [*provider's name(s)*] _____ to use and disclose a copy of the specific health information described below regarding [*employee/applicant's name*] _____, date of birth _____, consisting of:

_____

_____

_____

to: Office of Civil Rights Investigations and Compliance Dept. (OCIC)
Oregon Health & Science University
Mail code PP244b
3181 SW Sam Jackson Park Road
Portland, OR 97239
Fax: 503 346-8037
Email: ocic@ohsu.edu

This information is being provided to OCIC to evaluate and facilitate a need for reasonable accommodation.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS-related records*

_____ Mental health information*

_____ Substance use disorder, diagnosis, treatment, or referral**

** Must be initialed to be included in other documents.*
*** Federal regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.*

This authorization does not cover, and the information to be disclosed should not contain genetic information. "**Genetic information**" includes Information about an individual's genetic tests; Information about genetic tests of an individual's family members; Information about the manifestation of a disease or disorder in an individual's family members (family medical history); An individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and Genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

This authorization is limited to the following treatment:

_____

This authorization is limited to medical treatment during the following time period:

_____

I understand that the information used or disclosed according to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict the re-disclosure of HIV/AIDS information, mental health information, substance use disorder, diagnosis, treatment, or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the healthcare services are solely to provide health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to:

Office of Civil Rights Investigations and Compliance Department (OCIC)
Mail code PP244b
3181 SW Sam Jackson Park Road
Portland, OR 97239
Fax: 503 346-8037
Email: ocic@ohsu.edu

SIGNATURE

I have read this authorization and I understand it.

Printed Name: _____

Signature: _____

Today's Date: _____

Expiration Date of Medical Release:* _____

* Unless otherwise indicated, this authorization expires one year from the date this release is signed.