# OHSU Request Form: Workplace Accommodations for Pregnancy, Childbirth, and Related Medical Conditions

Employees and applicants should use this form to request reasonable accommodations needed due to pregnancy, childbirth, and related medical conditions.
***You are encouraged to fill out this form as early as possible***.

## 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 the OCIC with questions at 503 49**4-5148**.

**Email**: ocic@ohsu.edu
**Fax**: 503 346-8037

**U.S. Mail**: Office of Civil Rights Investigations and Compliance (OCIC)
Oregon Health & Science University
Mail code PP244B
3181 SW Sam Jackson Park Road
Portland, OR 97239

## YOUR RIGHTS

Employees and applicants have a right to be free from unlawful discrimination, harassment, or retaliation due to pregnancy, childbirth, and related medical conditions. 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 are encouraged to review the OHSU Pregnancy, Birth, and Adoption Leave Guide[1] and the OHSU websites for Family Life[2] and Pregnant and Parenting Employees.[3]

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**.

[1] https://o2.ohsu.edu/human-resources/documents/upload/pregnancy-birth-adoption-guide.pdf
[2] https://o2.ohsu.edu/spark/workplace-wellness/dependent-care.cfm
[3] https://www.ohsu.edu/title-ix/pregnant-and-parenting/employees

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 24/7.

**Request Form: Workplace Accommodations for Pregnancy, Childbirth, and Related Medical Conditions**

*Employees and applicants should use this form to request reasonable accommodations needed due to pregnancy, childbirth, and related medical conditions.*

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

Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Personal Email:_____

Work Email:_____

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. When is/was your due date?

2. Please describe the reasonable accommodation(s) you are requesting, and when you need them to start. Be as specific as possible.

3. Is there any other information that would help us evaluate your request?[4]

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

If you have a recent statement from your healthcare provider stating workplace restrictions or needed accommodations and/or the projected duration, 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 pregnancy accommodations law and/or 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 Department. (OCIC). A photocopy of the attached medical release shall have the same force and effect as the original.

**Signature of Person Requesting Accommodation:**

Name: _____ Date: _____

[4] 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.

**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 Department (OCIC)
Oregon Health & Science University
Mail code PP244b
3181 SW Sam Jackson Park Road
Portland, OR 97239

**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: 503-494-8810
Email: ocic@ohsu.edu

## SIGNATURE

I have read this authorization and I understand it.

Printed Name: _____ Expiration Date of Medical Release:* _____

Signature: _____ Today's Date: _____

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