Western Oregon UNIVERSITY

ACCOMMODATION REQUEST FORM

Part I – To Be Completed by Employee/Applicant Before Providing to Medical Provider		
Employee/Applicant Name		V #
Position Title	Department	Supervisor/Manager
Email Address	Contact Number ☐ Home _____ ☐ Mobile _____	
Employee Signature	Date of Request	

Part II – To Be Completed by Medical Provider		
Physician's Name	State of Certification or License	License/Certification Number
Type/Practice Specialty	Office Address	Office Telephone Number

A. Questions to help determine whether the employee/applicant has an impairment limiting a major life activity

Does the employee/applicant have a physical or mental impairment that limits a major life activity?

Yes ☐ No ☐

If yes, please select all life activities that are affected by the employee/applicants impairment:

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐Operation of a major bodily function
☐ Breathing	☐ Interacting with Others	☐ Reading	☐ Standing	
☐ Caring for Self	☐ Learning	☐ Seeing	☐ Thinking	☐ Other_____
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☐ Working	

B. Questions to help determine which reasonable accommodations may assist the employee/applicant in job performance.

The employee's job description is attached. Based upon the job description, does the employee/applicant's limitation(s) interfere with or limit his/her ability to perform the employee's essential job function(s) or access a benefit of employment?

Yes ☐ No ☐

If yes, in what way does their impairment prevent them from being able to perform which essential job function(s)?

Do you have any suggestions regarding possible reasonable accommodations that will permit the employee/applicant to safely and satisfactorily perform all the tasks you assert that the employee/applicant is precluded from performing?	Yes ☐	No ☐
If yes, what are they?		
How would your suggestions enable the employee/applicant to perform the essential function(s) of their job?		
What is the expected duration of the employee/applicant's need for such accommodations?		
D. Questions or comments:		
Medical Provider's Signature	Date	

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 do 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 members 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.

Western Oregon University Contact:
Name: Desiree Noah Title: Executive Director Phone: (503) 838-8963

Employee/applicant should return this completed and signed form to Human Resource, 345 Monmouth Ave., N, Room 307, Monmouth OR, 97361. The form can also be emailed to noahd@wou.edu or faxed to (503) 838-8522. If faxing this form please call (503) 838-8963 to verify receipt.