CSUDH | HUMAN RESOURCES MANAGEMENT

1000 East Victoria Street, WH 340
Carson, California 90747
PHONE: (310) 243-3771 FAX: (310) 928-7256

REASONABLE ACCOMMODATION REQUEST FORM FOR EMPLOYEES AND APPLICANTS

Request for New Accommodation ☐ Request for Accommodation Extension ☐ Date of Disability Onset: _____

Employee Name: _____ Employee Phone: _____

Employee Address: _____ Employee ID: _____

Position Title: _____ Department: _____

Work Hour: _____ am/pm to _____ am/pm Workdays: Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐

Workspace Location (Building, Floor, Suite): _____ Is this request due to a work-related injury? Yes ☐ No ☐

Appropriate Dept. Administrator's Name: _____ Dept. Administrator's Ext: _____

Primary Medical Provider Name: _____ Medical Provider Phone: _____

Are you participating in the FERP program Yes: ☐ No: ☐

A "reasonable accommodation" is a modification or adjustment to a job, the work environment, or the way things usually are done, that enables a qualified individual with a disability to enjoy an equal employment opportunity. The purpose of an accommodation is to assist an individual with performing the essential functions of their job.

Reasonable accommodations may include but are not limited to:
A modified work schedule, provision of special equipment, workplace accessibility modifications, shifting of non-essential duties of the employee's position, or a leave of absence to allow time for recovery, therapy, training, or other disability-related needs. The Appropriate Administrator of your department will decide whether an accommodation can be provided.

I am requesting a reasonable accommodation for the following reason: (Choose Only One)

☐ I am applying for employment, and a reasonable accommodation is necessary to comply with your application procedures and/or to safely and effectively perform the essential functions of the desired position listed above.

☐ I am a current employee of CSUDH, and I am requesting a reasonable accommodation to perform the essential functions of my existing position.

☐ I am a current employee of CSUDH, and I am applying for an alternate position within the organization. A reasonable accommodation may be necessary to ensure I can safely and effectively perform the essential functions of the position I am applying for.

Provide the work limitation prescribed by your medical provider. (**Please do not disclose your diagnosis**). (**example: no sitting for more than 2hrs per day; no walking; etc.)**

What specific accommodation(s) are you requesting?

How will the requested accommodation(s) assist you with performing the **essential functions** of your job? **(Please refer to your position description).**

Have you requested FMLA, CFRA, PDL, or other leave in connection with the above-described disability?

Yes ☐ No ☐

If yes, please specify what you requested and when:

Have you had any reasonable accommodations in the past for this same limitation(s) that were effective? Or, is there any additional information you would like to provide for consideration?

Yes ☐ No ☐ If yes, please provide below:

You may provide a copy of your position description to your Primary Medical Professional to assist with their review for consideration for an accommodation. If you need a copy of your position description:

- **Staff may request a copy of their position description from CSUDH Human Resources**
- **Faculty may request a copy of their position description from CSUDH Faculty Affairs.**

I verify that the above information is true and correct to the best of my knowledge and agree to allow this information be reviewed by the necessary parties to enable my accommodation. I understand that electronic copies of medical notes I submit to Human Resources will be maintained electronically in a separate, secure file contained in Human Resources in accordance with HIPAA regulations.

Employee Name (Print) **Employee Signature and Date**

I acknowledge the employee's request. This is not an approval of the accommodation Request.

Appropriate Dept. Administrator Name (Print) **Appropriate Dept. Administrator Signature & Date**

Questions please all ADA Coordinator at ext. 3771

The information requested above is CONFIDENTIAL and will be used to determine an appropriate reasonable accommodation for your work-related limitations due to a qualifying disability. This form is to be completed by the employee or a representative acting on behalf of the employee and provided to Human Resources. Please submit the completed form by email ADAmedicalaccommodations@csudh.edu. You may also deliver the completed form to Human Resources, Welch Hall 340, Phone (310) 243-3771.

Or send via U.S. mail to:

California State University, Dominguez
Hills Human Resources
Attention: ADA Coordinator
1000 E. Victoria Street, WH 340
Carson, CA 90747

*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 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 or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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MEDICAL RECORDS RELEASE AUTHORIZATION:

I, _____, hereby authorize California State University, Dominguez Hills, or its agent, to contact my physician/health care provider. I authorize my physician/health care provider to release information pertaining to my accommodation request to California State University, Dominguez Hills, Human Resources, about my functional abilities/limitations in relation to my job duties.

I hereby acknowledge I have been informed of my right to receive a copy of this authorization upon request. I further acknowledge I have been informed that if the medical information covered herein is not released, my request for a reasonable accommodation may be denied. I understand this authorization shall become effective immediately upon execution.

Employee Signature _____Date _____

Return this form to:

Human Resources, California State University Dominguez Hills
1000 E. Victoria Street, WH 340
Carson, CA 90747

Or send via secured email to:

ADAmedicalaccommodations@csudh.edu.

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