REQUEST FOR ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT (ADA) FORM

Enclosed please find the Request for Accommodation under the Americans with Disabilities Act (ADA) Form. This form should be completed when an employee is requesting a reasonable accommodation under ADA in order to perform the essential functions of their job. Such request must have supporting medical documentation. This means that the employee has to provide information sufficient to show that they have a disability that impairs their ability to perform major life functions. Major life functions include but are not limited to: caring for oneself, walking, seeing, hearing, speaking, breathing, learning, working, and performing manual tasks.

The completion of the request for accommodation form should not be considered as an approval, but rather a document to initiate a review of your request. You will be notified of the decision in writing.

Please be advised that when an accommodation is granted, it will be exclusively for the employee's specific job assignment and work location at the time of the review. Approved accommodations may be subject to re-evaluation, for example, if there are changes in work assignments and/or work location, medical condition, and/or the essential functions of the job are impacted.

For more information and to start the review and the interactive process, please submit to Fran Almeida Pistilli, Executive Director of Human Resources, the completed Request Form with the supporting documentation required including: the job description, and Certificate of Healthcare Provider (WH-380).

Definitions:

1. **Individual with a disability**:

   · Has a physical or mental impairment that substantially limits one or more major life activities; or
   · Has a record or history of such an impairment; or
   · Is perceived or regarded as having such impairment.

2. **A qualified individual with a disability**:

   · Is able to perform the essential functions of a job, with or without reasonable accommodation.

3. **"Reasonable Accommodation**" means any modification or adjustment to the work environment, or circumstances under which a position is customarily performed, enabling a qualified individual with a disability to perform the essential functions of the position.

   · LSCC will reasonably accommodate the known physical or mental limitation of an employee with a disability unless the accommodation would impose an undue hardship to the College.

4. **The Medical Statement** certified by a medical professional must define employee's disability, precise limitations imposed, and the expected frequency and duration of the disability.

   · Questions may be asked as to how this disability would substantially limit the employee's ability to perform the essential function(s) of their job, with or without a reasonable accommodation.

Lake Sumter State College

A.

EMPLOYEE REQUEST FOR ACCOMMODATION UNDER AMERICANS WITH DISABILITIES ACT

Employee Name:_____ Position Title:_____

Employee ID:_____ Hours of Work: _____

In support of your request for an accommodation under the Americans With Disabilities Act, please provide the following information and attach the required medical certificate:

Nature of Disability:

_____
_____
_____

Does the impairment affect a major life activity? Yes ☐ No ☐

If *yes*, what major life activity(s) is/are affected?

☐ Caring For Self ☐ Interacting With Others ☐ Performing Manual Tasks ☐ Breathing
☐ Working ☐ Walking ☐ Standing ☐ Reaching ☐ Thinking ☐ Toileting
☐ Hearing ☐ Seeing ☐ Speaking ☐ Learning ☐ Sitting ☐ Lifting
☐ Sleeping ☐ Concentrating ☐ Reproduction ☐ Other: (describe)

_____
_____
_____
_____

Accommodation Requested: _____
_____
_____
_____
_____

(Please use the back for additional information)

I understand that you may have questions about my request and may need to contact my medical provider. I hereby give you permission to do so: ☐ Yes ☐ No

Employee/Applicant Signature: _____ Date: _____

Lake Sumter State College

B.

Medical Provider Report for ADA

Date:_____

Employee Name:_____

The following questions may help determine whether an employee has a disability:

1. Does the employee have a mental or physical impairment? ☐ Yes ☐ No

If yes, what is the impairment?

_____

_____

_____

_____

2. Does the impairment substantially limit one or more major life activities? ☐ Yes ☐ No

If *yes*, what major life activity(s) is/are affected?

☐ Caring For Self ☐ Interacting With Others ☐ Performing Manual Tasks ☐ ☐ Breathing
☐ Working ☐ Walking ☐ Standing ☐ Reaching ☐ Thinking ☐ Toileting
☐ Hearing ☐ Seeing ☐ Speaking ☐ Learning ☐ Sitting ☐ Lifting
☐ Sleeping ☐ Concentrating ☐ Reproduction ☐ Other: (describe)

_____
_____
_____
_____

3. Describe the nature, severity and anticipated duration of the impairment.

☐ Temporary (explain)

_____
_____
_____
_____

A person has a disability under the Americans with Disabilities Act (ADA) if the person has an impairment that substantially limits one or more major life activities.

☐ Temporary but will take longer than normal to heal (explain)

_____
_____
_____
_____

Anticipated healing period:

_____
_____
_____
_____

☐ Temporary with residual effects (explain)

_____
_____
_____
_____

☐ Permanent

☐ Chronic (explain)

_____
_____
_____
_____

4. Please list any specific functional limitations resulting from the impairment.

_____
_____
_____
_____
_____
_____
_____
_____
_____

5. The employee's job description is attached hereto. How do the functional limitations listed above impact the employee's ability to perform the essential functions identified?

6. If you answered "Yes" to question # 1, are there any reasonable accommodations you would suggest that may enable him/her to perform the essential functions identified? If so, what suggestions do you have?

7. Additional Questions/Comments:

Name of Medical Provider_____ **License #**_____
Address _____ **Phone No.**_____
_____ **Fax No.**_____

_____ _____
Medical Professional's Signature **Date**