SNOW COLLEGE
HUMAN RESOURCES

REQUEST FOR DISABILITY ACCOMMODATION(S)

The College's Disability accommodation process is intended to be interactive and collaborative, relying on open communication and active participation between you and the College. The primary goal of this process is to assist you to perform all of the essential functions of your current position with or without accommodation. Human Resources (HR) will work with you to determine if reasonable accommodations can be made based on your documented disability and the essential functions of your job.

1. Request for Accommodation: Please fill out Part A of this form to notify the College that you are requesting accommodation(s) and to describe the impact that the disability has in regard to performing your job.

2. Release of Records: In order to document your disability and to verify the need for accommodation(s), additional medical information may be needed. Part B of this form is a release of records for you to sign so that your health care provider can release medical information to Snow College.

3. Medical Certification – ADA Accommodation Form: Please submit your completed Release of Records (Part B), the Medical Certification – ADA Accommodation Form (Part C), and a written job description that includes the essential functions (both mental and physical demands of your position) to your health care provider. If you need a copy of your job description, please work with your supervisor and/or Human Resources to obtain one.

4. Temporary Accommodations: Once you have submitted your Request for Disability Accommodation Form (Part A), HR will consult with you and your supervisor to determine if temporary accommodation(s) can be made until the Medical Certification for ADA Accommodation (Form C) is received from your medical provider. Completed documentation must be submitted to Human Resources within 15 days of your request for accommodation. HR will notify you in writing whether or not the temporary accommodation(s) can be provided.

5. Evaluation of Documentation: Upon receipt of documentation from an employee's health care provider, the College will determine if the employee has a disability as defined by relevant law, and if the employee can perform the essential functions of her/his position, with or without reasonable accommodation.

6. Second Opinion: Human Resources may contact the employee's health care provider for clarification of the written evaluation. If warranted, HR may also, at the College's expense, seek a second opinion. The employee must make him/herself available for such an evaluation.

7. Final Determination and Notification: Once the information has been gathered and analyzed to make an informed decision regarding your request, HR will meet with you to discuss the determination. You will receive written notification of the determination and if accommodation(s) have been approved, HR will also notify your supervisor of the accommodation(s) that will need to be provided to you.

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REQUEST FOR DISABILITY ACCOMMODATION FORM (Part A)

Employee Name: ______________________________ Employee ID: ____________________

Job Title: _____________________________________ Work Phone: ____________________

Supervisor Name: _____________________________ Department: _____________________

College Email: ____

Home Address: ______________________________________ Cell phone: ____________________

____

Describe your disability (e.g. visual impairment, arthritis, etc.) and the substantial limitation it causes in performing a major life activity:

Describe how your disability impairs your ability to perform assigned job duties:

Describe any potential reasonable accommodations that would overcome the above limitations:

__________________________________ ______________________________

Employee Signature **Date**

Release of Information

REQUEST FOR DISABILITY ACCOMMODATION FORM (Part B)

I,____, hereby authorize
(Patient Name)

____ to furnish and discuss with Snow College,
(Physician or Facility)

Human Resource Office any information in his/her/its possession relevant to the following condition: *(list condition(s) or diagnosis (es))*: ____

____, for the purpose of evaluating my request for accommodation. A complete photocopy of this authorization shall be accepted as if it were a signed original and is valid from the date of this release until the College completes its evaluation of my request for accommodation of this condition. I release ____________________________________ from any
(Physician or Facility)
liability associated with the disclosure of confidential or privileged medical/healthcare information. I understand that Snow College Human Resources cannot properly evaluate my request for accommodation unless I sign this release and that any information disclosed under this release could potentially be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that I can revoke this release in writing at any time by sending a written revocation of authorization to:

Snow College Human Resources
Attn: Employee Relations Specialist
150 College Avenue
Ephraim, UT. 84627

However, I understand that my revocation will not be effective to the extent that action has been taken in reliance on this release. By signing this release, I represent that I have read the information, understand it, and am in agreement with the authorization I now make.

_______________________________________ ________________________________
(Signature) *(Date)*

Name of Physician or Treatment Facility: ____

Address of Physician or Treatment Facility: ____

____

Telephone Number: ____

Medical Certification for ADA Accommodation

REQUEST FOR DISABILITY ACCOMMODATION FORM (Part C)

Name of Medical Provider: ______________________________

Mailing Address: ______________________________

City, State, Zip Code: ______________________________

Name of Patient (Snow College Employee): ______________________________

Dear Medical Provider,

I have made a request for reasonable accommodation(s) under the Americans with Disabilities Act of 1990. As you may be aware, the law requires that an individual assessment of my condition and needs be considered when granting an accommodation. Please review your files and respond to the listed questions to assist my employer in determining any possible accommodation(s).

1. What is the diagnosis according to the International Classification of Diseases (ICD 11) or Diagnostic and Statistical Manual (DSM V) of my condition?

2. What functional limitations do I have because of my diagnosis?

3. As an employee, how would the functional limitations caused by my condition affect my ability to complete the duties outlined in my job description?

4. How long will I, as the employee, need a reasonable accommodation? If unable to provide date, when will I be medically reevaluated?

5. Is it your opinion that I am able to perform the essential functions of my position, as you understand them, with or without a reasonable accommodation?

Please feel free to offer any additional comments you believe might help determine what accommodation(s) might be appropriate.

____________________________________ ___________________________

Physician Name (Please Print) Date

____

Signature of Physician completing form

Please contact Snow College Human Resources Employee Relations Specialist with any questions or concerns about completing this form

Phone Number: (435) 283-7043
Cell Phone Number (970) 893-3186

Please email or fax the completed form to:
Snow College Human Resources
Employee Relations Specialist
HR@snow.edu
Fax #: (435) 283-7261
Phone #: (435) 283-7043