EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM

The purpose of this form is to assist in determining whether, or to what extent, a reasonable accommodation is required for an employee to perform the essential functions of his or her job safely and effectively. For additional information on Reasonable Accommodations, see FAST-247 Access to Reasonable Accommodations Policy for Employees and Applicants for Employment.

This form, in its entirety, is to be returned to the following divisions of CCU:
- COVID-19 Related Accommodation Request: compliance@coastal.edu
- Reasonable Accommodations under the ADA: ada@coastal.edu

If necessary, the University will submit your medical release to the designated medical provider for additional information.

NAME: ________________________________ DEPT: ______________________

POSITION TITLE: _____________________________________________________

CCU ID#: __________________ PHONE NUMBER: ______________________

Relevant Definitions:
Disability- A physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such impairment; or bring regarded as having such an impairment.
Reasonable Accommodation- Any change in the workplace or the way things are customarily done that provides an equal employment opportunity to an individual with a disability.

1. Identify and describe the physical or mental disability illness, condition, or disease that is the basis for your request for reasonable accommodation(s):

____________________________________________________________________
____________________________________________________________________

2. Identify and describe the essential function(s) of your job that you are unable to perform without reasonable accommodation(s):

____________________________________________________________________
____________________________________________________________________

3. Identify and describe the reasonable accommodation(s) needed to enable you to perform the essential functions of your job properly and safely, including special equipment, changes in the physical layout of the work area, or other accommodations:

____________________________________________________________________

Employee Name: _______________________

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4. Identify and describe any equipment, aids, or services that you are willing to provide and utilize:


5. Along with this form, provide current documentation prepared by a medical professional or health care provider that describes your diagnosis, the functional limitations this diagnosis causes, and the accommodations or services necessary to address the diagnosis. Please be aware that CCU may contact these providers for additional information, if necessary.

6. If applicable, along with this form, provide historical documentation regarding accommodations the employee has previously received to address the disability.

**Employee Certification:**

I certify that I have read and reviewed the job description for my job or position and/or been informed of the essential functions of my job. I further certify that the foregoing statements are complete, accurate, and true to the best of my knowledge, and I understand that a misstatement or omission of fact may be cause for dismissal. I also understand Coastal Carolina University may require me to undergo testing or evaluation by medical personnel retained by the University for the purpose of establishing the existence and extent of my disability, illness, condition, or disease and my ability to perform job-related functions with or without reasonable accommodation.

SIGNATURE: _________________________________ DATE: _______________
AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

This form will be submitted to your medical provider by CCU, if additional information is necessary. Please do NOT submit this form to your medical provider.

Employee/Patient Name: __________________________________________________________

Date of Birth: ______________________ Telephone Number: __________________________

Healthcare Facility: ______________________________________________________________

Physician Name: ______________________ Telephone Number: _________________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with my request for a reasonable accommodation under the Americans with Disabilities Act. I expressly request that the designated record custodian listed above disclose full and complete protected medical information including any information they deem relevant to the decision of a reasonable workplace accommodation.

I understand that I may revoke this authorization at any time by providing such revocation, in writing, to my health care professional identified above or to HREO.

SIGNATURE: ______________________ DATE: ______________________

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To be completed by the employee/patient’s medical professional:

For reasonable accommodation under the ADA, an employee has a disability if they have an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability under the ADA.

<table>
<thead>
<tr>
<th>Does the employee currently have a physical or mental impairment?</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
</table>

If yes, what is the impairment or the nature of the impairment?

<table>
<thead>
<tr>
<th>Is the impairment temporary?</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
</table>

If yes, what is the expected duration of the impairment?

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Answer the following question based on what limitations the employee has when their condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity as compared to most people in the general population? If yes, how does this limitation impact the employee’s ability to do the essential functions of their job?

<table>
<thead>
<tr>
<th>Yes ☐</th>
<th>No ☐</th>
</tr>
</thead>
</table>

If yes, what major life activity(s) (includes major bodily functions) is/are affected?

- [ ] Bending
- [ ] Breathing
- [ ] Caring For Self
- [ ] Concentrating
- [ ] Eating
- [ ] Hearing
- [ ] Interacting With Others
- [ ] Learning
- [ ] Lifting
- [ ] Performing Manual Tasks
- [ ] Reaching
- [ ] Reading
- [ ] Speaking
- [ ] Standing
- [ ] Seeing
- [ ] Sitting
- [ ] Sleeping
- [ ] Working
- [ ] Other: (describe)

Major bodily functions:

- [ ] Bladder
- [ ] Bowel
- [ ] Brain
- [ ] Cardiovascular
- [ ] Circulatory
- [ ] Digestive
- [ ] Endocrine
- [ ] Genitourinary
- [ ] Hemic
- [ ] Immune
- [ ] Lymphatic
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] Normal Cell Growth
- [ ] Operation of an Organ
- [ ] Reproductive
- [ ] Respiratory
- [ ] Special Sense Organs & Skin
- [ ] Other: (describe)

Please provide any additional information you believe to be pertinent in the University’s decision regarding the employee/patient’s accommodation.

When completed, please return this form to Coastal Carolina University via confidential fax at 843-349-2045.

MEDICAL PROVIDER SIGNATURE: ___________________________ DATE: __________

Employee Name: ________________________

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