SKIDMORE COLLEGE

REASONABLE ACCOMMODATION FORM – DISABILITY

Skidmore College (the "College") is committed to providing equal employment opportunities without regard to any protected status. As such, the College is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested, the College will provide reasonable accommodation for any known medical condition or disability of a qualified individual, provided the requested accommodation is reasonable and does not create an undue hardship for the College or pose a direct threat to the health and/or safety of others in the workplace, educational environment, residence halls (if applicable) and/or to the requesting employee.

To request a reasonable accommodation, please complete Part A of this form, have your healthcare provider complete Part B (certification of a medical condition) and return this form to Human Resources. This information will be used by Human Resources to engage in an interactive process to determine eligibility for an accommodation and, if applicable, to determine the reasonable accommodation(s) that can be provided to enable the employee to perform the essential functions of their position without causing an undue hardship on the College or posing a direct threat of harm to self or others. Failure to provide this information may impact the College's ability to effectively engage in the interactive process and to provide a reasonable accommodation.

PART A – TO BE COMPLETED BY EMPLOYEE

Name: _____ Job Title: _____

Supervisor: _____ Unit/Department: _____

I verify that the information I am submitting in support of my request for accommodation is complete and accurate to the best of my knowledge and that any intentional misrepresentation contained in this request may result in corrective action.

I hereby authorize my medical provider to release my medical information to Skidmore College for the purposes of engaging in the interactive process to determine the availability of reasonable accommodation(s) of my medical condition. I understand that I may revoke this authorization in writing at any time, except that such revocation will not apply to any disclosures or actions taken in reliance on such disclosures up to the date of revocation. I have read and understand this authorization.

_____ _____

Signature Date

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PART B – TO BE COMPLETED BY MEDICAL PROVIDER

SKIDMORE COLLEGE - Restrictions Checklist

This checklist is intended to identify an employee's restrictions resulting from his/her physical or mental impairment. This form is to be completed by the employee's physician and returned to the employer.

Name of employee: _____

Description of condition: _____

Approximate date condition commenced: _____

Probable duration of condition: _____

Please identify the employee's restrictions by marking those items the employee may <u>not</u> do with an "X"; where not completely restricted – identify limitation (e.g., maximum pounds, hours).

- ❍ Lifting or exerting force – no more than _____ lbs.
- ❍ Bending/twisting/turning
- ❍ Climbing or balancing
- ❍ Kneeling
- ❍ Reaching or stretching
- ❍ Crouching or stooping
- ❍ Creeping or crawling
- ❍ Fingering or manual dexterity
- ❍ Repetitive finger motion
- ❍ Speaking
- ❍ Hearing
- ❍ Smelling
- ❍ Tasting
- ❍ Seeing (with correction)
- ❍ Perform CPR/First Aid
- ❍ Walking – no more than _____ hours per day
- ❍ Standing – no more than _____ hours per day
- ❍ Sitting – no more than _____ hours per day
- ❍ Working outdoors
- ❍ Working more than _____ hours per day/week

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<u>Select One</u>:

_____ It is unknown at this time how long these restrictions will remain in place.

_____ These restrictions will remain in place until: _____
(Date)

NOTE: If you do not provide the expected duration of restrictions, it will be assumed that the duration is unknown and a determination will be made based on that assumption.

Employee will be re-evaluated on: _____
(Date)

Please describe the accommodation(s) being sought and how the accommodations will be effective in allowing the employee to perform the functions of the job.

_____

_____

_____

_____

_____ _____
Signature of Health Care Provider Date

_____ _____
Print Name Telephone Number

_____
Office Address

_____

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 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.

Please return all three (3) pages via:

Mail:
The Skidmore College Human Resources Department
815 North Broadway, Saratoga Springs, NY 12866-1632

Email:
Jsklein@skidmore.edu

Fax:
518-580-5805