Iowa Department of Administrative Services
DAS
Human Resources Enterprise

REQUEST FOR REASONABLE ACCOMMODATION

(Please Print or Type)

SECTION A

EMPLOYEE INFORMATION

(This section must be completed by the employee/applicant requesting an accommodation.)

1. **Employee/Applicant Name:** _____
2. **Work Location:** _____
3. **Work Phone Number:** _____
4. **Email Address:** _____
5. **Description of requested accommodation:**

   _____
   _____

6. **This accommodation is necessary because:**

   _____
   _____
   _____
   _____
   _____
   _____

_____ _____
Signature (Employee/Applicant) *Date*

SECTION B

SUPERVISOR INFORMATION

(This section must be completed by the supervisor of the employee requesting an accommodation *prior* to submission to a medical provider.)

1. **Supervisor's Name:** _____

2. **Work Location:** _____

3. **Work Phone Number:** _____

4. **Email Address:** _____

5. **Date Request Received from Employee/Applicant:** _____

6. **Supervisor's comments/recommendations on employee/applicant requests, and list of accommodations already provided to the employee/applicant, if applicable:**

   _____
   _____
   _____
   _____
   _____
   _____

7. **Medical Provider Referral Required?** ☐ **Yes** ☐ **No If yes, Supervisor must list the essential job function(s) in Section C(4).**

_____ _____
Signature (Supervisor) *Date*

SECTION C

MEDICAL INQUIRY FORM IN RESPONSE TO AN ACCOMMODATION REQUEST

(This section must be completed by a medical provider.)

As discussed, the form will be returned to the supervisor by: _____.
(date)

Employee/applicant must notify the supervisor of any changes that may impact the submission of the form.

1. Questions to help determine whether an employee has a disability.

A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. The following questions may help determine whether an employee has a disability:

Does the employee/applicant have a physical or mental impairment? Yes ☐ No ☐

What is the impairment? _____

Is the impairment long-term or permanent? Yes ☐ No ☐

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

If yes, what major life activity(ies) 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)

Is the employee/applicant substantially limited in one or more of these major life activities? Yes ☐ No ☐

2. Questions to help determine whether an accommodation is needed.

An employee/applicant with a disability is entitled to an accommodation when such a change to a job, the work environment or the way things are usually done would allow the individual to perform job functions or enjoy equal access to benefits available to other individuals in the workplace. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with the employee's/applicant's ability to perform the essential function(s) of the job?

How does the employee's/applicant's limitation(s) interfere with his/her ability to perform the essential function(s) of the job?

3. Questions to help determine effective accommodation options.

If an employee/applicant has a disability and needs an accommodation because of the disability, the employer must provide reasonable accommodation(s), unless the accommodation(s) poses an undue hardship on the operations of the organization and/or causes direct threat to the health and safety of applicants, employees or others. The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations to improve the employee's/applicant's ability to perform the essential function(s) of the job? If so, what are they?

How would your suggestions improve the employee's/applicant's ability to perform the essential function(s) of the job?

4. Assess whether essential job function(s) can be performed:

Yes	No	Yes, with Reasonable Accommodation	Essential Function/Duty
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	
☐	☐	☐	
		Explain:	

5. Additional Comments:

_____
_____
_____
_____
_____
_____

6. Medical Provider Information:

Name (printed): _____
Address: _____
Telephone: _____

_____ _____
Medical Professional's Signature *Date*

SECTION D

APPOINTING AUTHORITY'S DECISION

1. The following accommodation(s) is(are) approved:

_____
_____
_____
_____
_____
_____

2. The following accommodation(s) is(are) not approved:

_____
_____
_____
_____
_____
_____

3. The reason(s) for not approving the accommodation(s) requested is(are):

_____
_____
_____
_____
_____
_____

_____ _____

Signature (Appointing Authority) *Date*

(Attach more pages or documents as needed)