State of Minnesota – [Agency Name]
Employee/Applicant Request for Americans with Disabilities Act ("ADA")
Reasonable Accommodation Form

The State of Minnesota is committed to complying with the Americans with Disabilities Act ("ADA") and the Minnesota Human Rights Act ("MHRA"). To be eligible for an ADA accommodation, you must be 1) qualified to perform the essential functions of your position and 2) have a disability that limits a major life activity or function. The ADA Coordinator/Designee will review each request on an individualized case-by-case basis to determine whether or not an accommodation can be made.

Employee/Applicant Name:	**Job Title:**
Work Location:	**Phone Number:**

Data Privacy Statement: This information may be used by your agency human resources representative, ADA Coordinator or designee, your agency legal counsel, or any other individual who is authorized by your agency to receive medical information for purposes of providing reasonable accommodations under the ADA and MHRA. This information is necessary to determine whether you have a disability as defined by the ADA or MHRA, and to determine whether any reasonable accommodation can be made. The provision of this information is strictly voluntary; however, if you refuse to provide it, your agency may refuse to provide a reasonable accommodation.

A. Questions to clarify accommodation requested.

1. **What specific accommodation are you requesting?**

2. **If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore?**

   YES NO

   a. **If yes, please explain.**

B. **Questions to document the reason for the accommodation request *(please attach additional pages if necessary).***

1. **What, if any, job function are you having difficulty performing?**

2. **What, if any, employment benefits are you having difficulty accessing?**

3. **What limitation, as result of your physical or mental impairment, is interfering with your ability to perform your job or access an employment benefit?**

4. **If you are requesting a specific accommodation, how will that accommodation be effective in allowing you to perform the functions of your job?**

Information Pertaining to Medical Documentation: In the context of assessing an accommodation request, medical documentation may be needed to determine if the employee has a disability covered by the ADA and to assist in identifying an effective accommodation. The ADA Coordinator or designee in each agency is tasked with collecting necessary medical documentation. In the event that medical documentation is needed, the employee will be provided with the appropriate forms to submit to their medical provider. The employee has the responsibility to ensure that the medical provider follows through on requests for medical information.

This authorization does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: Information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

Employee/Applicant Signature: _____

Date: _____

State of Minnesota – Minnesota State University, Mankato
Authorization for Release of Medical Information FOR AMERICANS WITH DISABILITIES ACT ("ADA") REASONABLE ACCOMMODATIONS

Date: _____

To: _____
Medical Provider Name

_____
Medical Provider Address

_____
City *State* *Zip Code*

_____
Fax Number

RE: _____
Patient Name *Date of Birth*

_____
Patient Address

_____
City *State* *Zip Code*

Genetic Information Nondiscrimination Act of 2008 Disclosure: **This authorization does not cover, and the information to be disclosed should not contain, genetic information. "Genetic Information" includes: Information about an individual's genetic tests; information about genetic tests of an individual's family members; information about the manifestation of a disease or disorder in an individual's family members (family medical history); an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.**

Authorization for Release of Medical Information for ADA, Page 2

I authorize _____ [Name of Healthcare Provider] to disclose to Diane Roggow, or any other person, including the agency's legal counsel, who is authorized by my employer to receive medical information that is specifically related and necessary to determine whether I have a disability and whether accommodations can be made. I also authorize Diane Roggow, or others as listed above, to speak to my treating health care provider directly in regards to any questions with respect to my condition as it relates to the performance of the essential functions of my job and any accommodations that may be necessary.

I understand that the requested data is for the above-mentioned purposes only, and that I may refuse to provide the requested medical information. However, I understand that if I refuse to provide this information, my employer may refuse to provide reasonable accommodations. I also understand that this information shall remain confidential, available only under limited conditions specified under law.

This authorization is valid for one year from the date indicated below or upon receipt of my signed written notice to withdraw my consent. A photocopy is as valid as an original.

Patient Signature: _____

Date: _____

State of Minnesota – Minnesota State University, Mankato
Letter Requesting Documentation for Determining Americans with Disabilities Act ("ADA") Eligibility from a Medical Provider

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Date: _____

To: _____
Medical Provider Name *Medical Provider Address*

RE: _____
Employee Name *Date of Birth*

The above employee has requested a reasonable accommodation under the Americans with Disabilities Act ("ADA"), as amended, to enable the employee to perform the essential functions of his/her position. The information requested on this form will assist us in making a determination regarding the employee's request. An Authorization for Release of Medical Information is attached to this document.

INSTRUCTIONS: Please complete the following form and have it signed by the employee's attending health care provider. Attach additional pages as needed. Do not provide information not related to the employee's ability to perform his/her job duties. For example, do not identify the impairment if it does not have an impact on the employee's ability to do his/her job. **Please do not send copies of medical records.** We are not authorized to have medical records and are not qualified to interpret them.

Medical Inquiry Form in Response to an ADA Reasonable Accommodation Request

Please complete each section and fax back your signed and dated original form using the contact information below.

A. Questions to help determine whether the employee has a disability.

1. **<u>Existence of impairment:</u>** For reasonable accommodation under the ADA, the employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such impairment.

   Does the employee have a physical or mental impairment?

   YES NO

   a. **If yes, what is the impairment?**

2. **<u>Limitations on major life activities:</u>** Answer the following question based on what limitations the employee has when his or her 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, assistive technology, auxiliary aids or services, prosthetics, etc. 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?

   YES NO

   a. **If yes, what major life activity(s) (including major bodily functions) is/are affected? (Please circle).**

Bending	Hearing	Reaching	Speaking
Breathing	Interacting with Others	Reading	Standing
Caring for Self	Learning	Seeing	Thinking
Concentrating	Lifting	Sitting	Walking
Eating	Performing Manual Tasks	Sleeping	Working
Other (Describe):			

Major Bodily Functions:

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

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

   Temporary (explain):

   Anticipated duration:

   Temporary with residual side effects (explain):

   Permanent:

   Episodic/In Remission (explain):

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

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability.

1. **What limitation(s) is interfering with job performance or accessing a benefit of employment?**

2. **What job functions or benefits of employment is the employee having trouble performing or accessing because of the limitation(s)?**

3. **How does the employee's limitation(s) interfere with his/her ability to perform the job function(s) or access a benefit of employment?**

C. Question to help determine effective accommodation options.
If an employee has a disability and needs an effective accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

1. **Do you have any suggestions regarding possible accommodations to improve job performance?**

   YES NO

   a. If so, what are they?

2. **How would your suggestions improve the employee's job performance?**

D. Other Questions or Comments:

Health Care Provider Information:

Name: _____

Address: _____

Phone Number: _____

Signature: _____ **Date:** _____

Please return the completed form to the ADA Coordinator at Minnesota State University, Mankato at the following fax number: 507-389-2960. If you experience difficulty faxing this form, please call Diane Roggow (ADA Coordinator) at 507-389-2016.

Thank you in advance for your prompt reply to the questions in the attached medical inquiry form.

Sincerely,

Diane Roggow

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