



EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORMS

IMPORTANT NOTICE: Information contained within this document is confidential! Do not share any information contained herein with your manager, supervisor, or colleagues.

1. Complete the Forms:

- i. **Request for Reasonable Accommodation** – the employee must answer all questions and sign the Acknowledgment of Request for Accommodation.
- ii. **SECTION A – Employee’s Statement & Authorization to Obtain Information** – must be completed and signed by the employee requesting the accommodation(s).
- iii. **SECTION B – Employee’s Treating Provider’s Medical Statement** – must be completed by the employee’s medical provider supporting the request for an accommodation.

2. Hand deliver, fax, or email completed forms to:

**Rush University Medical Center
Employee and Corporate Health Services
1650 W. Harrison St., Atrium 476
Chicago, IL. 60612
Phone: (312) 942-5878 Fax: (312) 942-8021
ECHS_ReasonableAccommodations@rush.edu**

OR

**Rush Oak Park Hospital
Employee Health Services
520 S. Maple Ave., Suite 263
Oak Park, IL. 60304
Phone: (708) 660-3271 Fax: (708) 660-2605
ECHS_ReasonableAccommodations@rush.edu**

4. Schedule an appointment to see an Employee Health Provider by calling or visiting your hospital’s Employee Health

Additional Notes:

- All sections must be received and completed in their entirety to schedule an accommodation forms review with the Employee Health provider.
- The employee must be seen in person by the Employee Health provider to complete an additional required section. This is required of all employees requesting a reasonable accommodation.
- After the employee is seen by the provider in Employee Health, completed forms are sent to Employee Labor Relations. All update requests should be directed to [Employee Labor Relations@rush.edu](mailto:Employee_Labor_Relations@rush.edu).
- All accommodation requests that require a re-evaluation must repeat the same steps outlined above.
- A job description must be obtained by the employee via their manager and given to the provider supporting the accommodation request to review. Form will be considered incomplete without the provider acknowledging this requirement.
- For more information regarding the reasonable accommodation process, please reference the **HR-E 0.700 ADA Accommodation Request** policy.

The Medical Center fully endorses the ADA, as well as Section 504 of the Rehabilitation Act of 1973, and will not tolerate discrimination and/or harassment of disabled employees as defined by the Americans with Disabilities Act.

Name: _____

Employee ID: _____

Request for Reasonable Accommodation

Please read this document carefully. Once you have completed the requested information and signed the Acknowledgement below, return this document along with the required supporting medical documentation to Employee and Corporate Health Services. Do not submit this information to your manager.

Rush is committed to recruiting and retaining a diverse workforce and establishing and maintaining an inclusive culture where all are welcomed and set up for success.

By completing and submitting this form with the supporting medical documentation, you are initiating a request for a reasonable workplace accommodation. A reasonable accommodation is any change in the workplace or to the way things are customarily done which provides an equal employment opportunity to an individual with a disability.

While there are some things that are not considered reasonable accommodations (e.g., removal of an essential job function or the provision of personal use items such as a hearing aid that is needed on *and off* the job), reasonable accommodations can cover most things that enable an individual to apply for a job, perform a job, or have equal access to the workplace and employee benefits such as kitchens, parking lots, and office events.

Common methods and forms of accommodations include, but are not limited to:

- modified work schedules
- granting breaks or providing leave
- altering how or when job duties are performed
- removing and/or substituting a marginal job function
- moving to different office space
- making changes to workplace policies
- providing assistive technology, including information technology and communications equipment or specially designed furniture
- removing an architectural barrier, including reconfiguring workspaces
- providing accessible parking, and/or
- providing materials in alternative formats (e.g., Braille, large print), etc.

Please complete the questions below to clarify your Accommodation Request

What specific accommodation are you requesting?

If you are not sure what accommodation is needed, do you have any suggestions about the options we should explore?

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Name: _____

Employee ID: _____

Is your accommodation request time sensitive? If yes, please explain.

Please specify the job functions you are having difficulty performing.

What, if any, employment benefits are you having difficult accessing?

What, if any, limitation is interfering with your ability to perform your job or access an employment benefit?

Have you had any accommodations in the past for this same limitation? If yes, what was the accommodation and was it effective?

Please provide any additional information that might be useful in our evaluation of your request.

Acknowledgement of Request for Accommodation

I am requesting an accommodation under the Americans with Disabilities Act. I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process. I understand that, in most cases, I will need to provide current medical documentation regarding my disability to assist in determining a reasonable accommodation. I further understand that, in some cases, discussion(s) of my disability with my physician may be necessary to address my request for an accommodation. In addition, if deemed necessary, Human Resources may request an independent medical evaluation of my disability.

I agree to participate in the interactive process to evaluate my request and I understand that if my request is granted, I am obliged to report any changes in my disability status which may require a reevaluation of this request.

Signature of Requestor

Date

The Medical Center fully endorses the ADA, as well as Section 504 of the Rehabilitation Act of 1973, and will not tolerate discrimination and/or harassment of disabled employees as defined by the Americans with Disabilities Act.

Name: _____

Employee ID: _____

SECTION A – Employee’s Statement & Authorization to Obtain Information

Employee Information and Informed Consent for Disclosure of Health Care Information. The employee’s signature on this form authorizes Rush and its relevant designee(s) to obtain medical information from the employee’s medical provider.

Employee Name: _____ <small>(Last) (First)</small>		Employee ID: _____	
Contact Information	Mailing Address: _____ <small>(City, State, Zip)</small>		
	Preferred Phone: (____) _____ - _____	<input type="checkbox"/> Home	<input type="checkbox"/> Mobile
	Personal Email: _____ @ _____		
Job Position: _____	Supervisor’s Name: _____		
	Supervisor’s Title: _____		
Employee’s Signature: _____		Date: _____	

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Name: _____

Employee ID: _____

SECTION B – Employee's Treating Provider's Medical Statement

Instructions: Review the provided job description to consider the employment/work essentials such as work schedule, performance, essential functions, and interpersonal expectations. **Complete Section B in its entirety.**

Treating Provider's Name: _____		Practice Name (If applicable): _____
Contact Information	Address: _____ <small>(City, State, Zip)</small>	
	Phone: (____) _____ - _____	Fax: (____) _____ - _____
	Email address: _____	
Treating Provider's Signature: _____		Date: _____
Is the patient's condition of a physical nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient's condition of a mental nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is the medical diagnosis/diagnoses as it pertains to the accommodations request?		
Brief medical facts regarding patient's condition (include objective findings and functional limitations):		
I have reviewed the provided job description.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient able to perform all the functions of their job <i>without</i> an accommodation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient able to perform all the functions of their job <i>with</i> an accommodation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What specific accommodation(s) are needed and recommended?		
How long is/are the accommodation(s) anticipated to be needed?		
How often should the accommodation(s) be re-evaluated?		

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