LEE COLLEGE

Employee ADA Accommodation Request Form

HUMAN RESOURCES OFFICE
Rundell Hall, Room 201
Office: 281.425.6875 ● Fax: 281.425.6568
Email: hr@lee.edu ● Website: www.lee.edu/hr

Instructions: Individuals who are employed at Lee College and are requesting a reasonable accommodation(s) under the Americans with Disabilities Act (ADA) are encouraged to complete this form in its entirety.

In addition, you must also have your health care provider complete the Medical Inquiry Form and return it to the Human Resources Office.

In order to explore possible coverage and reasonable accommodations, information is required regarding your medical condition, essential job functions, applicable functional limitations and your requested accommodation(s). It is often necessary for staff of the Human Resources Office to discuss your medical condition and the documentation you submit with providers such as licensed physicians, psychologists or other qualified professionals.

Please contact Human Resources at 281.425.6875 or hr@lee.edu, if you have any questions or need assistance completing this form. Return the completed form(s) directly to the LC Human Resources Office using one of the methods below:

- Fax: 281.425.6568
- Email: hr@lee.edu
- Mailing Address: Lee College HR Office, P.O .Box 818, Baytown, TX 77522-0818

EMPLOYEE AND JOB INFORMATION

Date of Request: _____

Employee Name: _____

Job Title: _____

Department: _____

Email Address: _____

Phone #: _____

Supervisor's Name: _____

Supervisor's Title: _____

Email Address: _____

Phone#: _____

Briefly describe the essential functions of your position. If needed, please attach a job description.

MEDICAL CONDITION

Please describe the medical condition for which you are requesting an accommodation:

Is the medical condition temporary or permanent? ◯ Temporary ◯ Permanent

If the condition is temporary, what is the anticipated duration of the condition?

Please explain how the medical condition affects your ability to perform your job.

ACCOMMODATION

Please provide your recommendations for any reasonable accommodation(s) related to your disability that would help you meet the essential functions of your current job.

Describe any accommodations or assistive technologies you currently use.

Has a physician, vocational rehabilitation specialist or other health professional recommended a specific accommodation? ◯ Yes ◯ No

If yes, please attach a copy of their recommendations. If you do not have the documentation, please list the diagnostics you have had completed and with which medical provider the records reside.

Please provide any additional information that you believe is relevant to your request for an accommodation.

DOCUMENTATION

Please submit copies of any/all medical documentation you have to support your request.

ACKNOWLEDGEMENT

I understand that the Human Resources Office is permitted to share relevant information from my health care provider(s) with the supervisor(s) in my immediate work unit and other College personnel that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work-related responsibilities.

I understand that Human Resources Office has my permission to contact my physician or other health care provider(s) for additional information to assist in developing reasonable accommodations for me.

I understand that I must also submit the **Request for Reasonable Accommodation — Medical Inquiry Form** signed by an authorized physician or other health care provider. This form should include a description of my disability, any related limitations and recommendations for accommodation(s) and/or service(s).

I understand that Human Resources will evaluate and respond to me based upon the information that I provide.

Employee Signature: _____ Date: _____

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Request for Reasonable Accommodation Medical Inquiry Form

**** To be completed by Health Care Provider only ****

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To the Medical Professional:

The employee below requested job modification based on a medical condition. Lee College (LC) requires diagnostic documentation from a licensed medical, psychological or other diagnostic professional (such as an audiologist for hearing impairments) when an employee is making a request for accommodations based on disability. It will benefit both the employee and LC for you to complete this form as specifically as possible. Feel free to attach any relevant supplementary documentation.

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Your assistance is greatly appreciated!

EMPLOYEE INFORMATION

Employee Name: _____

DETERMINATION OF DISABILITY

Does the employee have a physical or mental impairment? ◯ Yes ◯ No

If yes, what is the impairment/diagnosis?

Date of Diagnosis: _____

Is the impairment: ◯ Temporary/Short-Term ◯ Permanent

If temporary/short-term, how long will the impairment likely last?

Answer the following questions 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, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned

behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit one or more major life activities? ◯ Yes ◯ No

If yes, which major life activity(es)?

- ☐ Walking
- ☐ Standing
- ☐ Lifting
- ☐ Bending
- ☐ Breathing
- ☐ Eating
- ☐ Sleeping
- ☐ Hearing
- ☐ Seeing
- ☐ Thinking
- ☐ Reading
- ☐ Speaking
- ☐ Communicating
- ☐ Learning
- ☐ Concentrating
- ☐ Working
- ☐ Performing Manual Tasks
- ☐ Caring for Self
- ☐ Other: _____

Does the impairment substantially limit operation of one or more major bodily functions? ◯ Yes ◯ No

If yes, what bodily function(s)?

- ☐ Digestive
- ☐ Genitourinary
- ☐ Bowel
- ☐ Bladder
- ☐ Neurological
- ☐ Brain
- ☐ Respiratory
- ☐ Circulatory
- ☐ Cardiovascular
- ☐ Endocrine
- ☐ Hemic
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Reproductive
- ☐ Immune System
- ☐ Special Sense Organs & Skin
- ☐ Normal Cell Growth
- ☐ Other: _____

ACCOMMODATIONS

Job Title: _____

Department: _____

Summary of Essential Duties: (Job Description should be provided.)

Does the disability affect the employee's ability to perform the essential functions of the job? ◯ Yes ◯ No

If yes, please indicate how the disability limits the employee's performance of essential functions of the position.

Identify possible accommodations that may enable the employee to perform the essential job functions.

How will your suggestions improve the employee's ability to perform the essential job functions?

How long do you expect this accommodation to be necessary?

SIGNATURE OF MEDICAL PROFESSIONAL

Medical Professional Signature: _____ Date: _____

Printed or Typed Name: _____

Practice Name: _____

Office Address: _____

Office Phone: _____ Office Fax: _____