



EMPLOYEE REQUEST FOR REASONABLE ACCOMMODATION

It is the policy and practice of Racine County to provide reasonable accommodations, where possible, for qualified employees with disabilities, consistent with state and federal laws. As part of this policy and practice Racine County strives to work interactively with employees to identify potential barriers to job performance and potential reasonable accommodations related to those barriers. By engaging in this interactive process, Racine County is not identifying an employee as disabled, but is instead working in good faith to identify and provide reasonable accommodations.

The purpose of this form is to assist Racine County in determining whether and/or to what extent a reasonable accommodation is needed and/or can be made for a qualified employee with a disability to perform one or more essential functions of his/her job safely and effectively. The information in this form will be treated confidentially and will only be shared with those with a need to know the information.

In order to assess potential reasonable accommodations, it is necessary for us to gather specific information regarding your condition any related limitations and/or restrictions. As part of the interactive process, we would also like your input regarding potential reasonable accommodations that you may have identified. Please note that we are only inquiring about disabilities that are associated with a requested or potential accommodation. We are not inquiring about any disabilities/conditions which are unrelated to the need for an accommodation and/or a potential accommodation.

Please answer the following questions as it relates to the need for an accommodation, providing as much detail as possible, and attaching additional pages if necessary. Once Racine County has necessary information, we can work with you to determine what reasonable accommodations may be possible.

Name of Employee: _____

Position: _____

Department: _____

1. Please identify the disability and/or medical condition that requires the requested accommodation.

2. Do you believe that the disability and/or medical condition identified above affects and/or impairs your ability to perform one or more essential functions of your job? If so, please identify and describe the essential functions of the job that are impaired and/or affected by the disability and/or medical condition. (See attached Job Description).

3. Please identify and describe the reasonable accommodation(s) that you are requesting that you believe would allow you to perform the essential function(s) of your job that are affected and/or impaired by the disability and/or medical condition.

4. Are there any further reasonable accommodations that you would like to discuss and/or that you would like Racine County to explore? If so, please describe below.

5. Please include any additional information that might be helpful in assessing the request for reasonable accommodation.

Please provide us with a completed Physician Accommodation Questionnaire from your physician (the Questionnaire is attached to this form). Please note that simply completing this form does not mean we can or will accommodate your disability or medical condition nor does it mean this is the only information we will need to evaluate your request. However, it is the essential first step in determining whether we can provide you with an accommodation. Once we receive the information listed in this Request, we will schedule a meeting to review your condition and our options. Failure to provide the information requested in this form may prevent us from providing you with a reasonable accommodation.

Date: _____ Employee Signature: _____

EMPLOYEE REQUEST FOR REASONABLE ACCOMMODATION PHYSICIAN QUESTIONNAIRE

Name of Employee: _____

Name of Physician: _____

It is the policy and practice of Racine County to provide reasonable accommodations, where possible, for its employees with disabilities, consistent with state and federal laws. As part of this policy and practice, Racine County strives to work interactively with employees to identify potential barriers to job performance and potential reasonable accommodations related to those barriers.

Racine County is engaging with the employee identified above to assess whether and to what extent the employee may have potential barriers to job performance related to a disability and, and if so, what reasonable accommodation(s) may be provided to address those barriers.

As part of this process, Racine County requires basic information regarding the employee's medical condition and related restrictions/limitations related to the requested or potential accommodation. Please note that we are only inquiring about disabilities that are associated with a requested or potential accommodation. We are not inquiring about any disabilities/conditions which are unrelated to the need for an accommodation and/or a potential accommodation. Please feel free to attach additional information as necessary to fully respond to the questions below.

NOTE: 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 employees or their family members. In order 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.

1. Please identify the disability and/or medical condition that requires the requested accommodation(s) and describe the nature of the disability and/or medical condition.

2. What is the expected duration of the disability or medical condition?

3. Is the employee substantially limited in any major life activities as a result of the health condition? If so, please identify and describe in detail how the disability or medical condition limits or affects the employee in one or more major life activities.

4. Is the employee unable to perform any of the essential functions of his/her job (see attached)? If so, please describe

5. Does the condition result in any functional limitations (such as standing, sitting, bending, concentrating, etc.)? If so, please describe.

6. Please describe in detail any work restrictions and/or how the disability or medical condition may otherwise affect the employee's ability to perform the functions of his or her job.

7. What, if any, reasonable accommodation(s) do you believe would allow the employee to perform the functions of his or her job? If a leave of absence is recommended, please provide the duration, the estimated date you expect the employee to return to work, and the anticipated work restrictions, if any, upon the employee's return. If a reduced work schedule related to the condition is recommended, please identify the reduced work schedule and the anticipated duration of the same.

8. Please identify any additional information that you believe would assist the company in assessing and determining whether a reasonable accommodation(s) can be made

Name (printed): _____ Date: _____

Signature: _____