REQUEST FOR REASONABLE ACCOMMODATION

CITY OF TOLEDO SELF-IDENTIFICATION FORM FOR PEOPLE WITH DISABILITIES

1. Fill out the employee section (pages 1 to 4) of the reasonable accommodation request packet.
2. **Submit the forms to the ADA Coordinator, Diversity & Inclusion Dept, One Government Center, Suite 1900, or scan and email to: joan.easler@toledo.oh.gov**
3. The employee gives the Division/Department Head/Supervisor **Form B** to complete then submits it to the ADA Coordinator. Employee should inform the supervisor of their requested accommodation and the limitations they are experiencing.
4. The employee gives their physician the **Physician Statement Form** to complete the medical section. Attach any medical correspondence that will support your case. The physician has to state the reason that the person cannot perform the work function without having a certain accommodation be provided for them. Employee will secure the completed Physician Statement and submit to the ADA Coordinator.
5. The ADA Coordinator will arrange to meet with the employee first and Div/Dept Head/Supervisor at subsequent meetings to engage in the interactive process to discuss the accommodation not the disability. The ADA Coordinator will contact the employee to arrange the first meeting and will notify the supervisor that the employee will need release time.
6. The ADA Coordinator will send the Division/Dept Head a **COPY** of the letter addressed to the employee stating that their request for a reasonable accommodation has been approved or denied. The ADA Coordinator will state the accommodation that said employee should have and the reason why or why not.
7. The ADA Coordinator in the Office of Diversity & Inclusion will file the **ORIGINAL** Accommodation Form in a separate ADA employee file.
8. Diversity & Inclusion will maintain that information on file in the office.

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CITY OF TOLEDO SELF-IDENTIFICATION FORM FOR PEOPLE WITH DISABILITIES

As a Equal Opportunity Employer subject to the provisions set forth in section 504 of the Rehabilitation Act of 1973, and The American's With Disabilities Act of 1990, discrimination based on a disability is prohibited. The Acts also require the employer to provide a reasonable accommodation for employees or applicants with a known disability. This will enable such employees to perform the essential job functions of the position, or will provide, access to the workplace, identification of the disability and specific reasonable accommodation(s) is strictly voluntary; however necessary for the provisions set forth the Rehabilitation Act of 1973 and The American's with Disabilities Act of 1990 to become activated. The information submitted on this form will be handled in a non-discriminatory and confidential way; furthermore it will be maintained in a separate file apart from the employees personnel file.

Date: ____ __________________

Name: ____ __________________

Address____Zip________

Home Phone: ________________________ Work Phone:___________________

Work Address:____________________________________ __________________

Length of service with the City: _____________________ __________________

Position held:_____________________________________ __________________

Dept./Div./Agcy where employed: ___________________ __________________

Supervisors Name:________________________________ __________________

Date:____

Self-Identification Form NAME:

PLEASE CHECK ALL APPROPRIATE CATEGORIES

PHYSICAL OR MENTAL IMPAIRMENT		MAJOR LIFE ACTIVITIES
Physical disorder, contagious disease, cosmetic disfigurement, or anatomical loss in one or more system:	Mental or psychological disorder including:	Major life activities include: (Complete only if you require assistance in one or more of these areas.)
◻ Neurological ◻ Musculoskeletal ◻ Respiratory ◻ Cardiovascular ◻ Digestive ◻ Genito-Urinary ◻ Hemic ◻ Lymphatic ◻ Skin ◻ Endocrine	◻ Mental Retardation ◻ Organic Brain Syndrome ◻ Emotional or mental illness ◻ Specific learning disabilities	◻ Self care ◻ Manual tasks ◻ Walking ◻ Seeing ◻ Hearing ◻ Speaking ◻ Breathing ◻ Learning ◻ Working
◻ Substance Abuse*		

NAME____

CHECK ALL APROPRIATE CATAGORIES

◻ Partial loss of vision
◻ Reduced Concentration
◻ Handling/Fingering
◻ Reading
◻ Operating foot petal
◻ Decreased Stamina
◻ Standing
◻ Talking

◻ Total loss of vision
◻ Memory loss
◻ Squatting Bending
◻ Grasping
◻ Climbing
◻ Carrying
◻ Walking
◻ Balancing

◻ Hearing
◻ Pushing/Pulling
◻ Lifting
◻Kneeling
◻ Feeling/Sensing
◻ Sitting
◻ Learning

◻ Other (please specify

* Does not include a current illegal abuser

Side of body if applicable: ◻ Right ◻ Left

What type of accommodation would assist you in performing the essential functions of your job?____________________________

____

____

City of Toledo
Office of Diversity & Inclusion
Request for Reasonable Accommodation
Employee Form A

(To be completed by employee requesting the reasonable accommodation)

1. Employee Name:____

2. Department, division, or agency: _______________________________

3. Position/title:____

4. Immediate supervisor:____________________________________ __

5. Work Phone: _________________ Home Phone:_____________

6. Name of condition or disability: ___________________._______ ____

7. What Reasonable Accommodation are you requesting?_____________
____
____
____
____

8. What major life activity is substantially limited due to your disability?
____
____
____
____
____

Employee Signature:____

Date____

City of Toledo
Office of Diversity & Inclusion
Request for Reasonable Accommodation
Departmental Form B
(To be completed by Director, Commissioner or Agency Head, Supervisor)

1. Name of employee requesting accommodation(s)________________________
2. Employee's department and job title: ____________________________
3. Employee's immediate supervisor: _____________ ______________
4. Title and Phone number: ______________________________
5. Name of employee's disability, if known ____________________________
6. Reasonable accommodation requested, if known _______________________
7. Can the essential functions of the job be performed with the requested reasonable accommodations? Yes__________ No_________
8. If the department is unable to provide the requested accommodation, what alternative reasonable accommodation(s) could be provided to retain the employee in his/her current position able to perform the essential functions of the job?
   ____
   ____
   ____
   ____
9. Does the employee's department/division/agency have available financial resources to provide:

   (a) The requested accommodation? Yes____No____
   (b) The alternative reasonable accommodation? Yes ______ No____
10. Estimated annual cost to provide the requested accommodation and resources available:____
11. Can funds be transferred from another account to provide for the accommodation?
    _____Yes ______ No

12. If the requested or any reasonable accommodation can be provided, please indicate the date on which it will occur:____________________________

13. If the department is unable to provide the requested reasonable accommodation, please explain why it cannot be provided:________________________________
____
____
____
____
____

Administrator Signature/Title____
Date:____

City of Toledo
Office of Diversity & Inclusion
Request for Reasonable Accommodation
Physician's Medical Form

(To be completed by employee's physician)

1. Patient's Name: ____

2. Patient's department and job title:____________________________________

3. Please indicate how long you have treated the patient noted above:__________
____

4. Please indicate the medical name for the patient's condition/disability:_______
____
____

5. Under the Americans with Disabilities Act of 1990, a person with a disability has a physical or mental impairment that substantially limits one or more major life activities, has a record of such a disability, or is regarded as being disabled. Please indicate the substantially limiting impairment (includes unable to see, hear, walk, bend, climb, stand, etc.) of this patient:
____
____
____

6. Can this patient safely and substantially perform the essential job functions of their position with or without a reasonable accommodation?

Yes No

7. What reasonable accommodation do you recommend is necessary for this patient to perform then essential job functions?________________________________
____
____

8. Date of last examination?____

9. Physician 's Additional Comments:___________________________________
____
____
____

Physician Name Signature____

Physicians Name Print or Stamp____

Date____