PROCEDURE FOR REQUESTING AN ADA REASONABLE ACCOMMODATION

1. Follow the steps below to initiate the process.

   a. The employee completes an ADA Reasonable Accommodation Request Form (Attachment A) to acknowledge that the request is being made.

   b. The employee gives the Medical Information memo (Attachment B) and the Certification of Physical Disability/Medical Condition Form (Attachment C) to his/her physician who, in turn, will provide the required medical information.

   c. The employee then **submits the ADA Reasonable Accommodation Request Form to the Human Resources Department.**

      The Certification of Physical Disability/Medical Condition form and any additional medical information (records) should be submitted by the employee or medical provider to the Human Resources Department for a reasonable accommodation review. Documents should be sent to:

      Marquette University Office of Human Resources, Straz Tower #185,
      P.O. Box 1881
      Milwaukee, WI 53201-1881
      Telephone (414)288-7305
      FAX (414)288-7425

   d. If you have any additional questions regarding the ADA reasonable accommodation application process, please contact Lynn Mellantine, Assistant Vice President of Human Resources, Straz Tower 185, ext. 8-3430, lynn.mellantine@marquette.edu

An accommodation that is medically necessary is one that has a risk-avoiding or therapeutic value associated with the accommodation and will enable the employee to perform the essential functions of his/her job. On the other hand, if the review concludes that, based upon the accommodation assessment of the employee's medical information, an accommodation is not medically necessary or is not likely to be effective, the request for the accommodation may be denied.

C O N F I D E N T I A L

REQUEST FOR ADA REASONABLE ACCOMMODATION FORM (ATTACHMENT A)

Please complete the ADA Reasonable Accommodation Request form and submit the completed form to the Human Resources Department. Information received pertaining to an accommodation request is kept confidential to the extent possible and maintained separately from personnel records.

I. Employee Personal Information

Name: _____ Ext_____ Job Title: _____

Department: _____ Supervisor's Name: _____

II. Describe the essential functions of your job that you are unable to perform and the reasons why (attach additional page(s) if necessary). (Medical information pertaining to your disability will be required.)

_____

_____

_____

_____

_____

_____

III. Describe the accommodation(s) requested (attach additional page(s) if necessary):

_____

_____

_____

_____

_____

_____

_____

Employee Signature/Date

C O N F I D E N T I A L

MEDICAL INFORMATION
(ATTACHMENT B)

Please provide medical information from your medical doctor that describes your medical condition and describes any limitations placed on your major life activities and functions.

Please be certain to inform your doctor that your request for medical information is being made because you have applied for an ADA reasonable accommodation. Additionally, request that your doctor review the standards for the medical documentation information review listed below so that his/her reply provides the medical information requested to review your request in an efficient and thorough manner.

Medical information to be provided by a qualified health professional and attached to the Request for ADA Reasonable Accommodation Form:

1. Include a statement of the specific diagnosis of the disability.

2. Cite the diagnostic criteria and tests given, with dates (no more than 3 years since administration) results, and interpretations. Cite how the results support the diagnosis.

3. Describe the applicant's functional limitations due to the disability, and the impact of those limitations on physical, perceptual and cognitive abilities.

4. Recommend specific accommodation(s) and for each accommodation, provide a rationale as to how it will reduce the impact of the functional limitation(s).

5. State your professional credentials and any licenses you hold that support your qualifications to diagnose and/or treat this applicant's disabilities.

6. Send Documents to:

Marquette University Office of Human Resources, Straz Tower #185,
P.O. Box 1881
Milwaukee, WI 53201-1881
Telephone (414)288-7305
FAX (414)288-7425

CERTIFICATION OF PHYSICAL DISABILITY/MEDICAL CONDITION
(ATTACHMENT C)

The employee named below has applied for coverage under the American with Disabilities Act at Marquette University. In order to determine this employee's eligibility for reasonable and appropriate accommodations, we ask that you provide current and comprehensive information attesting to the employee's disability and documenting the functional impact of the disability.

Please take into consideration when completing this form:

1. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting may delay the eligibility review process by necessitating follow up contact for clarification.
2. The healthcare provider should attach any reports which provide additional related information. If a comprehensive diagnosis report is available that provides the requested information; copies of that report can be submitted for documentation as well.

If you have any questions please call the Office of Human resources at 414-288-7305. Thank you for your assistance.

Name of employee: _____ Date: _____

1. Is this employee currently under your care? _____Yes _____No

2. When did you last see this employee? _____

3. What is the diagnosis of the impairment? (Please use definitive language and avoid such speculative language as “suggests” or “could have problems”)

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   Date of diagnosis: _____

Section I

Major Life Activities Assessment

Please check which of the major life activities listed below are substantially limited because of the current condition. (Substantially limited is defined as a "significant restriction in the condition, manner, or duration in which a major life activity is performed compared to most people.")

Talking	_____	Seeing	_____
Hearing	_____	Sleeping	_____
Breathing	_____	Learning	_____
Standing	_____	Thinking	_____
Working	_____	Concentrating	_____
Reaching	_____	Memorizing	_____
Lifting	_____	Writing	_____
Sitting	_____	Interacting w/others	_____
Walking	_____	Caring for oneself	_____
Speaking	_____	Reading	_____

Employment Effects

I. How does this condition/impairment impact the employee's ability to perform his/her job? If this condition/impairment does not affect the employee's ability to work, please explain.

_____

_____

_____

_____

a. If the employee is currently undergoing medical treatment, please describe and indicate how this treatment might affect the employee's work.

_____

_____

_____

_____

b. Are there any situations that might lead to an exacerbation of the condition/impairment?

_____

_____

_____

_____

c. Please provide specific job accommodations with justification as to why these accommodations would be appropriate for the employee. *Please note - There may be limitations on the number of absences an employee is allowed based on job requirements.

i. Accommodation: _____

_____

Justification:_____

_____

ii. Accommodation: _____

_____

Justification:_____

_____

Accommodation:_____

_____

Justification**:**_____

_____

Is there anything else you would like us to know about this employee?

_____

_____

_____

Section II

Please sign, date and return to the employee.

_____	_____
Signature of Treating Professional	Date
_____	_____
Professional's Name (printed)	License Number
_____	_____
Professional's Title	Telephone Number
_____	_____
Address	Fax Number