Form to be completed by Employee and returned to the Department of Human Resources, 173 West Lorain Street, Oberlin, OH 44074 or via fax: 440-775-8438.

OBERLIN COLLEGE – Employee Disability Accommodation Request (DAR)

The DAR must be used when an employee seeks a workplace accommodation due to a documented disability. To request accommodation, an employee must:

- Complete the DAR form, and Section I of the attached Documentation of Disability (DOD) form. Ask your physician or health care provider to complete the attached ADA Physician Statement. Then submit all forms to Human Resources. Questions may also be directed to Human Resources at 440-775-8430.
- Provide a copy of your job description to your physician or health care provider.

The DAR and DOD forms are necessary to initiate a request for accommodation. If, after receiving all of the documentation, Oberlin College concludes the employee is eligible, we will consider what reasonable accommodations are possible under the circumstances. If an accommodation is granted, the accommodation will be reviewed periodically by Human Resources to determine whether updated documentation is needed and whether the accommodation is still appropriate and sufficient.

Section I: Contact Information (*to be completed by employee*)

Full Name of Employee: ____

Telephone: ___________________ Email: ___________________________________

Job Title: ____________________ Department & Work Location:_______________________

Full Name of Supervisor: __________________ Work Schedule: __________________________

Section II: Accommodation Request (*to be completed by employee*)

A. Indicate the physical or mental limitations and expected duration of limitations. Please note that it is not necessary to indicate a specific medical diagnosis. (Attach additional pages if necessary.)

____

____

B. Explain how the limitations affect the ability to successfully complete your job at Oberlin College.

____

____

C. Specifically describe the accommodations you are proposing.

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____

D. Add any comments you feel may be helpful in our consideration of your request.

____

____

Employee's Signature____________________ Date: _________________________

Section III: To be completed by Human Resources

Contacts made and options considered:_________________________________
Accommodation Request is: Approved Denied
Cost of Accommodation(s): _______________________________________

Form to be completed by Employee and his/her Physician and returned to the Department of Human Resources, 173 West Lorain Street, Oberlin, OH 44074 or via fax: 440-775-8438.

Documentation of Disability (DOD)

Section I: To be completed by employee

Employee Name ______________________ Job Title ______________________

Department ______________________ Supervisor Name ______________________

Release of Information

I hereby authorize the release of the following information to Oberlin College for the purpose of determining the availability of reasonable accommodations. I further authorize Oberlin College to seek clarification of this documentation if necessary by contacting my physician or health care provider.

Employee Signature ______________________ Date ______________________

ADA Physician Statement: To be completed by a physician or health care provider

To Physician or Health Care Provider:

To request reasonable and appropriate accommodations, employees must provide current documentation of a disability. Federal and state laws define a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. As the employee's physician or health care provider, you are asked to fully complete all sections on this form. Additional information can be attached if necessary.

To complete this form, you must review the employee's job description and other information relevant to the employee's job at Oberlin College. If those materials have not been provided, please contact the employee and let him or her know you cannot complete this form without those documents. Thank you for your assistance.

1. Please identify the employee's physical or mental impairment.

____

____

- Please describe the duration of this impairment (e.g. long-term, permanent, recent, short-term)

2. Please describe the effects or limitations this impairment has on the employee's activities or functions of daily living.

____

____

3. By reviewing the attached information concerning the employee's job duties, please describe the effect or limitations this impairment has on the employee's ability to perform specific job duties, if any.

____

____

- Are there any activities or situations that should be avoided or that would present a health or safety risk to the employee or others due to the impairment?

____

____

4. Please offer any suggested accommodations that might enable the employee to perform his or her job duties.

- ____
  _________________________Duration?________________
- ____
  _________________________Duration?________________

_______________________________________ _____________________

Signature of physician or health care provider Date

____

Provider name (printed)

Type of practice: ___________________________ Phone #: _______________

Address: ____