



# Reasonable Accommodation Package



**Equal Employment Opportunity  
Office**

**651 31<sup>st</sup> Street**

**Fort Gordon, GA 30905**

**Tel: (706) 791-4551**



## APPENDIX B

### CONFIRMATION OF REQUEST AND CERTIFICATION FOR REASONABLE ACCOMMODATIONS

This form should be completed by an employee who believes they have a disability and who wish to request a reasonable accommodation. This form is used for record-keeping and reporting purposes only. It should be maintained separately from the employee's personnel file and is a confidential document. Please attach a separate sheet if more space is needed.

1. Today's Date  
\_\_\_\_\_
2. Employee's Name  
\_\_\_\_\_
3. Employee's Phone Number and E-mail Address  
\_\_\_\_\_
4. Employee's Title, Series & Grade  
\_\_\_\_\_
5. Employee's Agency/Directorate  
\_\_\_\_\_
6. Immediate Supervisor's Name  
\_\_\_\_\_
7. Immediate Supervisor's Phone Number and E-mail Address  
\_\_\_\_\_
8. Name and relationship of the person who initially received the request  
\_\_\_\_\_  
(Check all applicable)     Immediate supervisor     Another supervisor in the chain of command  
 Reasonable Accommodation Coordinator (RAC)     HR Specialist     EEO Specialist  
 Disability Program Manager (DPM)     Other \_\_\_\_\_
9. Original Date of Reasonable Accommodation Request  
\_\_\_\_\_
10. Briefly describe the medical condition requiring accommodation  
\_\_\_\_\_  
\_\_\_\_\_
11. Describe specifically what accommodation(s) you think could be made so that you could perform the essential duties of the position. You must be able to perform all of the critical elements outlined in your performance appraisal plan or in the vacancy announcement, either with or without accommodation.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Please check any of the categories below that apply to your request:

- Alternate Work Schedule
- Assistive Devices (*Non-CAP*)
- CAP request (*Computer or Electronic Office Equipment*)
- CAP request (*Computer Software*)
- Furniture
- Materials in alternative formats
- Parking
- Reconfigured work space
- Removal of an architectural barrier
- Scooters
- Sign Language Interpreter or Captioning Request
- Telework
- Other Request \_\_\_\_\_

13. Reasonable Accommodation needed for: (*Check all applicable*)

- Performing Job Functions
- Accessing the Work Environment
- Accessing a Benefit or Privilege of Employment: (*i.e., attending a training program or social event.*)
- Applicant

14. How long do you believe you would need the required accommodations?

\_\_\_\_\_

15. Explain any time sensitive issues related to the request.

\_\_\_\_\_

If a disability and/ or need for reasonable accommodation is not obvious or already on file with the Agency, the Agency has a right to request medical documentation to substantiate the disability and the requested accommodation. **If you have been asked to provide any medical information, the information should be attached to and submitted with this form, unless it has already been provided.**

### CERTIFICATION AND CONSENT BY EMPLOYEE

I hereby certify that all statements made above are true to the best of my knowledge and belief. I hereby give permission for the release of information about my service and medical condition(s) to agency officials with a need to know.

\_\_\_\_\_

Employee's Signature

Date

Daytime Phone Number

DPM LOG NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_

**Note:** This form should be completed by the employee making the reasonable accommodation request and provided to his/her supervisor. If a third party is completing the form on behalf of the employee or a management official is documenting an oral request, a copy of the completed form will be provided to the employee to confirm receipt of the request. Supervisors must provide a copy of this form to the EEO Disability Program Manager (DPM), who will assign a log number and return a copy of this form to the supervisor.

**APPENDIX D  
DISPOSITION OF REASONABLE ACCOMMODATION REQUEST**

**To Be Completed by Deciding Official.** This form is used for record-keeping and reporting purposes only. It should be maintained separately from the employee's personnel file and is a confidential document. Attach copies of all documents obtained or developed in processing this report form. **Please submit this form as soon as possible after final determination of the reasonable accommodation request to the servicing Disability Program Manager (DPM).**

1. Name and Title of Individual Requesting Reasonable Accommodation:  
\_\_\_\_\_
2. Agency/Directorate of Requesting Individual:  
\_\_\_\_\_
3. Reasonable accommodation: (*Check one*)
  - Approved
  - Denied (If denied, attach copy of the written denial letter/memo stating reason)
4. Describe the type of accommodation requested:  
\_\_\_\_\_
5. Describe the type of accommodation granted (if different from what was requested):  
\_\_\_\_\_
6. Date reasonable accommodation request referred to deciding official (*i.e., Supervisor, Office or Division Director, HR Specialist*): \_\_\_\_\_
7. Name and Title of Deciding Official: \_\_\_\_\_
8. Date reasonable accommodation approved or denied: \_\_\_\_\_
9. Date of disposition of the reasonable accommodation request (if different from date approved):  
\_\_\_\_\_
10. Interim measures provided, if any:  
\_\_\_\_\_
11. If time frames outlined for Reasonable Accommodation Procedures, were not met, please explain:  
\_\_\_\_\_
12. Request for reasonable accommodation denied because: (*You may check more than one box*)
  - Accommodation ineffective
  - Medical documentation inadequate
  - Accommodation would require removal of an essential function or otherwise would require lowering of performance or production standard
  - Accommodation would cause undue hardship

13. Detailed reason(s) for the denial of reasonable accommodation(s). Must be specific, (e.g. *why accommodation would be ineffective or cause undue hardship*).

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14. If the proposed reasonable accommodation was rejected but another one was offered and accepted, please explain.

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15. If the individual proposed one type of reasonable accommodation which is being denied, but rejected an offer of a different type of reasonable accommodation, explain both the reasons for the denial of the requested accommodation and why you believe the chosen accommodation would be effective.

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16. Was medical information required to process this request?  Yes  No

17. Sources of technical assistance, if any, consulted in trying to identify possible reasonable accommodations (e.g., Job Accommodation Network, disability organization, Reasonable Accommodation Coordinator).

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18. Comments:

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## **CERTIFICATION AND CONSENT BY DECIDING OFFICIAL**

I hereby certify that all statements made above are true to the best of my knowledge and belief.

**Deciding Official Signature      Date      Phone Number      Email Address**

For More information please contact:

### **Equal Employment Opportunity Office**

Attention: Disability Program Manager

651 31<sup>st</sup> Street

Fort Gordon, GA 30905

(706) 791-4551

### **If the Requestor is not satisfied with this decision, s/he may do the following:**

a. Direct a request for reconsideration to the person who issued the decision (the Deciding Official) in response to your request, or to a supervisor in that person's chain of command. Your request for reconsideration must be delivered no later than 30 business days from the date you received your decision. Please include a copy of the decision issued to you with your request and any additional information or arguments you choose to submit.

b. If an individual wishes to file an Equal Employment Opportunity (EEO) complaint, or pursue Merit Systems Protection Board Request (MSPB) or union grievance procedures, he/she must take the following steps:

- For an EEO complaint, contact the EEO office within 45 days of receipt of the decision;
- For an MSPB appeal, file within 30 days of an action that is appealable to the board; or
- For a collective bargaining claim, file a written grievance in accordance with appropriate grievance procedures.

c. Direct a request for Alternative Dispute Resolution (ADR) to the appropriate ADR program coordinator in your respective Agency within 15 days of the receipt of the decision.

**Special Note:** Each grievance/complaint procedure(s) timelines run congruently as of the date of the decision. In other words, timelines for the above procedures start on the date of the decision and do not hold for another filed procedure.

## **Privacy Act Advisory Statement**

The Privacy Act of 1974 requires that you be given certain information about this request for information. The authority for the accommodation request form is derived from the Rehabilitation Act of 1973, as amended, which stipulates that Federal agencies must provide reasonable accommodations to qualified individuals with disabilities. 29 U.S.C. Section 791; 29 C.F.R. Part 1614; see also 20 C.F.R. part 1630. Further, Executive Order 13164 mandates that Federal agencies have written procedures for providing reasonable accommodation and maintain records in order to monitor the effectiveness of the procedures. Completion of this form is voluntary, however, no accommodation may be given to a qualified individual without this written information. The EEO Disability Program Manager shall maintain a record of all accommodation requests, which will be utilized to determine the efficacy and consistency of the reasonable accommodation procedures process and be compiled for reports to the Equal Employment Opportunity Commission (EEOC); these records are subject to periodic review by the EEOC, at its request, to ensure compliance. Other routine uses are listed below.

### **Routine Uses**

1. In the event that a system of records maintained by the Agency to carry out its functions indicates a violation or potential violation of law or contract, whether civil, criminal, or regulatory in nature, and whether arising by general statute or particular program statute or contract, or rule, regulation, or order issued pursuant thereto, or the necessity to protect an interest of the Department, the relevant records in the system of records may be referred to the appropriate agency, whether Federal, state, local, or foreign, charged with the responsibility of investigating or prosecuting such violation or charged with enforcing or implementing the statute or contract, or rule, regulation, or order issued pursuant thereto, or protecting the interest of the Agency.
2. A record from this system of records may be disclosed to a Federal, state, or local agency maintaining civil, criminal, or other relevant enforcement information, or other pertinent information, such as current licenses, if necessary to obtain information relevant to a Department decision concerning the assignment, hiring, or retention of an individual, the issuance of a license, grant or other benefit.
3. A record from this system of records may be disclosed to a Federal, state, local or international agency, in response to its request, in connection with the assignment, hiring, or retention of an individual, the issuance of a security clearance, the reporting of an investigation of the individual, the letting of a contract, or the issuance of a license, grant, or other benefit by the requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter.
4. A record from this system of records may be disclosed in the course of presenting evidence to a court, magistrate, or administrative tribunal, including disclosures to opposing counsel in the course of settlement negotiations.
5. A record in this system of records may be disclosed to a Member of Congress submitting a request involving an individual when the individual has requested assistance from the Member with respect to the subject matter of the record.
6. A record in this system of records may be disclosed to the Department of Justice in connection with determining whether disclosure thereof is required by the Freedom of

Information Act (5 U.S.C. 552).

7. A record in this system of records may be disclosed to a contractor of the Agency having need for the information in the performance of a contract, but not operating a system of records within the meaning of 5 U.S.C. 552a(m).

8. A record in this system may be disclosed to the Office of Personnel Management for personnel research purposes; as a data source for management information; for the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained; or for related manpower studies.

9. A record from this system of records may be disclosed to the Administrator, General Services Administration (GSA), or his designee, during an inspection of records conducted by GSA as part of that agency's responsibility to recommend improvements in records management practices and programs under authority of 44 U.S.C. 2904 and 2906. Such disclosure shall be made in accordance with the GSA regulations governing inspection of records for this purpose, and any other relevant (i.e. GSA or Commerce) directive. Such disclosure shall not be used to make determinations about individuals.

10. A record in this system of records may be disclosed to any source from which additional information is requested in the course of processing a grievance to the extent necessary to identify the individual, inform the source of the purposes(s) of the request, and identify the type of information requested.

11. A record in this system of records may be disclosed to officials of the Office of Personnel Management, Merit Systems Protection Board, including the Office of the Special Counsel, the Federal Labor Relations Authority and its General Counsel, or the Equal Employment Opportunity Commission, the Department of State, or the Department of Labor when requested in performance of their authorized duties.

12. A record in this system of records may be disclosed in response to a request for discovery or for appearance of a witness, information that is relevant to the subject matter involved in a pending judicial or administrative proceeding.

13. A record in this system of records may be disclosed to officials or labor organizations reorganized under the Civil Service Reform Act when relevant and necessary to their duties of exclusive representation concerning personnel policies, practices, and matters affecting work conditions.

14. A record in this system of records may be disclosed to commercial contractors (debt collection agencies) for the purpose of collecting delinquent debts authorized by the Debt Collection Act (31 U.S.C. 3718).

15. A record in this system of records may be disclosed to Senior State Department officials at U.S. Embassies, including the Ambassador, Deputy Chief of Mission, Administrative Counselor and Human Resource Officers, for matters relating to employment or security issues pertaining to Department of Commerce employees working in U.S. Embassies or facilities overseas.

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION**

**PRIVACY ACT STATEMENT**

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

**AUTHORITY:** Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

**PRINCIPAL PURPOSE(S):** This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

**ROUTINE USE(S):** To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

**DISCLOSURE:** Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

**SECTION I - PATIENT DATA**

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one)	
	<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH

**SECTION II - DISCLOSURE**

6. I AUTHORIZE \_\_\_\_\_ TO RELEASE MY PATIENT INFORMATION TO:  
*(Name of Facility/TRICARE Health Plan)*

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS (Street, City, State and ZIP Code)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)

<input type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> SCHOOL	<input type="checkbox"/> OTHER (Specify)
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION	<input type="checkbox"/> LEGAL	

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE (YYYYMMDD)      10. AUTHORIZATION EXPIRATION

<input type="checkbox"/> DATE (YYYYMMDD)	<input type="checkbox"/> ACTION COMPLETED
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**SECTION III - RELEASE AUTHORIZATION**

I understand that:

- a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
- b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
- d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT <i>(If applicable)</i>	13. DATE (YYYYMMDD)
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**SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)**

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE		SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER: