Mississippi Valley State University
Office of Human Resources

AMERICAN WITH DISABILITY ACT (ADA)
REASONABLE ACCOMODATION REQUEST FORM

Mississippi Valley State University is required by law, and it is the policy of the University to provide reasonable accommodation to qualified employees with known disabilities, when requested and if appropriate, absent undue hardship to the University. Employees who believe themselves covered by the Act and wish to benefit under Mississippi Valley State University Affirmative Action Plan are asked to identify themselves via this request form. All information will be considered confidential except in the following instances (1) supervisors may be informed regarding work restrictions or accommodations; (2) emergency response workers may be informed for first aid purposes; (3) governmental officials investigating compliance of the Act will be informed. Choosing not to provide this information will not result in adverse treatment or disciplinary action.

PART A: (To be completed by the individual requesting accommodation) Name: (please print)
____ MVSU ID: _________________________ Home Address:
____
Home Phone: ______________________________ Cell Phone: ______________________________
Department/Division:
____ Work
Phone: ________________________________ Work Email:
____ Job Title for which Reasonable Accommodation is
Requested: ____ Date of the Request for
Reasonable Accommodation: ____________________________ Is your Request: Permanent Temporary
Unknown If temporary, anticipated date accommodation(s) no longer needed:
____

PART B: REQUEST FOR REASONABLE ACCOMODATION: I am requesting the following accommodation (list possible devices, equipment, or alternative methods/procedures) Use blank sheet for additional information REASON FOR REQUEST: I need an accommodation for the reasons stated below (list essential function(s) that cannot be fully performed, and/or job-related functional limitations) Use blank sheet for additional information By signing below, you are attesting that the information provided in this request is true and accurate and, understand that you may be required to provide verification by a health professional or a disability service provider. Please send this confidential document to: Office of Human Resources, MVSU 7260, 14000 Hwy 82 W, Itta Bena, MS 38941

Requestor's Signature: ____ Date: ____________

Mississippi Valley State University
Office of Human Resources
REASONABLE ACCOMMODATION QUESTIONAIRE
AMERICAN WITH DISABILITY ACT (ADA)

Employee Name: ______________________ **MVSU ID:** ______________

MEDICAL RELEASE:

I authorize the release of any medical information necessary to process the accommodation request.

Requestor's Signature: ______________________ **Date:** ______________

To be Completed by Health Care Provider

Please answer the following as it relates to the employee's request for an accommodation.

1. **When was your most recent evaluation of the employee?** ______________________

- **Does the employee have a physical or mental impairment?** Yes ☐ No ☐
  If yes, is the impairment long-term or permanent? Yes ☐ No ☐
  If no, how long will the impairment likely last? ______________________

2. **Does the impairment affect a major life activity?** Yes ☐ No ☐

   If yes, what life activity(s) is/are affected (check all applicable boxes below)?

☐ Caring for Self	☐ Breathing	☐ Thinking	☐ Learning	☐ Reproduction
☐ Interacting with Others	☐ Working	☐ Toileting	☐ Sitting	☐ Other: (describe)
☐ Performing Manual Tasks	☐ Walking	☐ Hearing	☐ Lifting	
	☐ Standing	☐ Seeing	☐ Sleeping	
	☐ Reaching	☐ Speaking	☐ Concentrating	

3. **Is the employee limited in one or more of the major life activities checked above?** Yes ☐ No ☐
   If yes, please describe the limitations.

4. **Employee currently works in the position of ______________________. Please review the attached job description for this position and identify any job function you believe Employee is unable to perform as a result of the condition(s) for which you are providing treatment.**

5. **How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?**

6. What accommodations, if any, may be made to Employee's job functions to enable Employee to perform the job functions listed in response to question #5 above without endangering Employee's health or safety or the health or safety of others in the workplace?

7. Are you aware of any medication Employee is taking that would limit Employee from performing the essential job functions described in the attached job description? If so, please describe the limitations and whether any accommodation would ameliorate the limitations.

8. You stated in your note dated ______________, that Employee may return to work on _____________. Is that return date reasonably definite?

   What is the likelihood you will require Employee to be off work for additional time?

9. Are there any alternatives to time off from work that would enable Employee to perform his/her job functions now or sooner than the additional time off you have prescribed? If so, please recommend those alternatives.

10. Is there anything else we should know that would be helpful for us to determine appropriate accommodations for Employee?

_______________________________________ _______________________________
Signature of Health Care Provider Date

_______________________________________ _______________________________
Health Care Provider's Name (please print) Telephone

_______________________________________ _______________________________
Address Fax

____
City State Zip