Print Form

MURRAY STATE UNIVERSITY

Office of Equal Opportunity and Title IX (OEO)
103 Wells Hall ■ Murray, KY 42071
Tel: (270) 809-3155 ■ Fax: (270) 809-6887
TDD: (270) 809-3361

REASONABLE ACCOMMODATION FORM

Application for FACULTY or STAFF with a Disability

SECTION I TO BE COMPLETED BY APPLICANT

Semester Applying for: ☐ Fall ___ ☐ Spring ___ ☐ Summer ___ M#: _____

Applicant Full Name: _____
Last First Middle Initial

Campus/Local Address _____
Street City State Zip

Campus/Local Phone: _____ Home Phone: _____

Home Address _____
Street City State Zip

MSU E-mail Address _____ Cell Number: _____

Classification: ☐ FACULTY ☐ STAFF ☐ RETIREE ☐ OTHER: _____

Current Department of Employment: _____

Job Title/Classification: _____

Work Location: _____

Supervisor's Name: _____ Phone: _____

Supervisor's email address: _____

Work Accommodation Requests – In addition to the completed form, attach the following supportive documentation:

☐ Official Job Description (visit HR website or call)
☐ Work Schedule (including work days and times)
☐ Class Schedule and Syllabi (FACULTY ONLY)
☐ Other: _____

A. I have the following physical or mental impairment(s): _____

B. That impairment restricts me as follows: _____

C. As a result, I am unable to perform the following activity _____ because I cannot _____

D. In order for me to engage in the activity mentioned in item C, I am requesting the following accommodation _____

By the signature below, I, the applicant, authorize the physician to complete Section III on the following pages, and to release information (including paper, oral, and electronic formats) regarding my medical condition. I understand that I can revoke this authorization at any time by submitting a written revocation. A revocation will not apply to information that has already been disclosed in reliance on an authorization. I understand that once the information is disclosed pursuant to this authorization it may be re-disclosed by the recipient and the information will no longer be protected by HIPPAA. This authorization will expire six (6) months subsequent to the day executed as indicated below.

Signature of Applicant _____ Date _____

Please return this completed form to the Office of Equal Opportunity and Title IX

SECTION II TO BE COMPLETED BY HUMAN RESOURCES

For EMPLOYMENT REASONABLE ACCOMMODATION REQUESTS ONLY

Please provide the essential job function for the below named position.

Position Title:_____

Please attach the job description for this position or job specifications.

> **Essential function descriptions should contain the physical and mental elements of performing them. Qualifications and standards must be job-related and consistent with operating necessity.** When preparing the memo regarding essential functions, include responses to the following questions: *Does the job exist to do this function? How much time per week is spent doing this function? What are the minimum qualifications and job standards? What critical skills, experience, training, education, and/or license are needed? What equipment is used to do this function? How frequently is the equipment used? What are the physical elements of this function? What are the mental elements of this function? Can other current employees do this function if necessary? Would taking this function from the job significantly change the job? Would there be significant consequences if this function were not performed? Could this function be redesigned or performed in another way? Did the previous employee do this function? Do people in similar positions elsewhere do this function? Is this function essential, as opposed to marginal?*

The Essential Job Functions for this position are:

SECTION III TO BE COMPLETED BY MEDICAL PROVIDER

1. Does the applicant have a physical and/or mental impairment which will limit his/her ability to perform the essential functions of the activity(ies) mentioned in item C? Yes No

If answered **YES,** to the above, please provide a description of the impairment and a diagnosis.

_____

_____

2. What limitation(s) does this impairment cause? _____

3. What is the expected duration of the impairment and the limitations? _____

_____

4. Is the applicant capable of performing the essential functions of the activity with reasonable accommodations? Yes No

If answered **YES**, to the above, please state the reasonable accommodations which are needed so the applicant can perform the essential functions of the activity(ies) mentioned in item C. _____

_____

_____

5. Please provide any additional information you believe is relevant to the applicant's impairment as it relates to his/her engaging in the activity(ies) mentioned in item C: _____

_____

_____

Physician/Medical Professional/ARPN Name (please print) _____

Area of practice/specialty: _____

Address _____

_____

Phone: _____ Fax: _____

Signature _____ Date _____

Return Form To:

The Office of Equal Opportunity and Title IX
103 Wells Hall
Murray, KY 42071
Phone: (270) 809-3155 Fax: (270) 809-6887
TDD: (270) 809-6831

APPEALS PROCESS

Any person seeking to appeal the decision must submit, in writing, a request to review the decision. This appeal must be delivered to the Office of Equal Opportunity and Title IX , within five (5) working days of receipt of the Executive Director's decision. The request shall state reasons why the party is requesting a review and may contain any information for consideration. The appeal will be referred to the Affirmative Action Subcommittee on Disabilities. The committee may confirm, amend, or modify the decision. The decision of the committee shall be final.