Workplace Accommodations Notice

Western Oregon University is an equal opportunity employer and does not discriminate on the basis of race, religion, color, sex, age, national origin, disability, veteran status, sexual orientation, gender identity, gender expression or any other classification protected by law.

Western Oregon University will make reasonable accommodations for known physical or mental disabilities of an applicant or employee as well as known limitations related to pregnancy, childbirth or a related medical condition, such as lactation, unless the accommodation would cause an undue hardship. Among other possibilities, reasonable accommodations could include:

- Acquisition or modification of equipment or devices;
- More frequent or longer break periods or periodic rest;
- Assistance with manual labor; or
- Modification of work schedules or job assignments.

Employees and job applicants have a right to be free from unlawful discrimination and retaliation

For this reason, Western Oregon University **will not**:

- Deny employment opportunities on the basis of a need for reasonable accommodation
- Deny reasonable accommodation for known limitations, unless the accommodation would cause an undue hardship.
- Take an adverse employment action, discriminate or retaliate because the applicant or employee has inquired about, requested or used a reasonable accommodation.
- Require an applicant or an employee to accept an accommodation that is unnecessary.
- Require an employee to take family leave or any other leave, if the employer can make reasonable accommodation instead.

To request an accommodation or to discuss concerns or questions about this notice, please contact Human Resource Services at noahd@wou.edu.

REASONABLE ACCOMMODATION REQUEST FORM

The purpose of this form is to assist the university in determining whether, or to what extent, a reasonable accommodation is required for an employee with a disability to perform one or more essential functions of their job safely and effectively. This form shall be filed separately from the employee's personnel file and be treated confidentially.

EMPLOYEE INFORMATION				
NAME:			V#:	
DEPARTMENT:		JOB TITLE:		
EMPLOYEE TYPE:	☐ Classified	☐ Faculty	☐ Unclassified	☐ Student
SUPERVISOR NAME:				
WORK SCHEDULE:				
CONTACT INFORMATION				
PERSONAL EMAIL:				
MAILING ADDRESS:				
PHONE:				

Please answer each of the following questions to assist us in understanding the basis and nature of your request for a reasonable accommodation (attach additional sheets if necessary).

1. What is the disability, medical condition, or impairment that is impacting your ability to perform the essential functions of your job[1]?

2. What specific accommodation are you requesting?

3. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? ☐ Yes ☐ No
   If yes, please explain:

4. Is your accommodation request time sensitive? ☐ Yes ☐ No
   If yes, please explain:

[1] The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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5. What, if any job function are you having difficulty performing?

6. What, if any, employment benefit are you having difficulty accessing?

7. What limitation is interfering with your ability to perform your job or access an employment benefit?

8. Have you had any accommodations in the past for this same limitation? ☐ Yes ☐ No
   If yes, what were they and how effective were they:

9. If you are requesting a specific accommodation, how will that accommodation assist you?

10. Is there any other information that would help us evaluate your request?

Medical information may be necessary as part of the interactive process. When an individual qualifies for reasonable accommodation, the employer is free to choose among effective accommodations, and may choose one that is less expensive or easier to provide.

____ ________________

Employee signature * Date

* This form does not need to be signed if submitted by email. The email submission represents the signature. The form may be signed by the person completing or the person completing it on their behalf.

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If you have a recent statement from your doctor stating your diagnosis, prognosis, any restrictions you may have with respect to your employment, and/or the projected duration of those restrictions, please attach it to this form. With your written consent, Western Oregon University may request necessary medical information from your healthcare provider(s). Your request for reasonable accommodation cannot be processed without information from your healthcare provider.

Attached is a medical release authorizing Western Oregon University to obtain medical information which is needed to evaluate a request for an accommodation under the Americans with Disabilities Act (ADA). I understand that all information obtained during this process will be maintained and used in accordance with ADA and all legal and regulatory requirements as they pertain to medical and genetic information confidentiality. I authorize my medical provider(s) to release such medical information, as indicated on the attached form, to Western Oregon University Human Resources. A photocopy of the attached medical release shall have the same force and effect as the original.

Healthcare Provider Contact Information			
Provider Name:			
Provider ADDRESS:			
PHONE:		Fax:	

Signature of Person Requesting Accommodation

________________________________ ______________
Employee Signature Date

Hand deliver, email, or mail this form to: Human Resources		
Hand Delivery Location Lieuallen Administration Room 307 Monmouth, OR	Mailing Address HR – Lieuallen Admin 307 345 Monmouth, Ave. N., Monmouth, OR 97736	Email noahd@wou.edu

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Pursuant to my request for reasonable accommodation under the Americans with Disabilities Act, my employer, Western Oregon University, is conducting an inquiry to determine: (1) my eligibility for a reasonable accommodation; (2) if I am eligible, what reasonable accommodation, if any, would be appropriate; (3) the feasibility of the reasonable accommodation; (4) any possible alternative reasonable accommodations.

I authorize [provider name(s)] ______________________________ to use and disclose a copy of the specific heath information described below regarding [employee name] ______________________________________ date of birth _______________, consisting of:

____

____

____

____

for the purpose of assisting my employer with my reasonable accommodation request.

To: Human Resources
Western Oregon University
Lieuallen Administration 307
Monmouth, OR 97361
Fax: 503-838-8522
Phone: 503-838-8963

This authorization does not cover, and the information to be disclosed should not contain, genetic information. "**Genetic information**" includes: Information about an individual's genetic tests; Information about genetic tests of an individual's family members; Information about the manifestation of a disease or disorder in an individual's family members (family medical history); An individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual; and Genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

This authorization is limited to the following treatment(s):

____

____

This authorization is limited to medical treatment during the following time period:

____

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, and treatment or referral information.

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You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the healthcare services are solely for the purposes of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, send a written statement to:

Desiree Noah
Human Resources
Western Oregon University
Lieuallen Administration 307
Monmouth, OR 97361
Fax: 503-838-8522

SIGNATURE

I have read this authorization and I understand it.

Printed Name: ________________________________ Expiration Date of Medical Release*: ____________

Signature: ___________________________________ Today's Date: ____________

*Unless otherwise indicated, this authorization expires one year from the date this release is signed.

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