



Office of Human Resource Services
Olympia, Washington 98505
(360) 867-5361/FAX (360) 867-6823

THE EVERGREEN STATE COLLEGE
REASONABLE ACCOMMODATION REQUEST FORM

NAME _____ JOB CLASSIFICATION _____

JOB TITLE _____

DIVISION/DEPT _____ PHONE NUMBER _____

SUPERVISOR _____ DATE OF REQUEST _____

The purpose of this form is to assist TESC in evaluating reasonable accommodation requests. Return the completed form to Human Resource Services.

TO BE COMPLETED BY THE EMPLOYEE:

- 1) Identify and describe the physical or mental disability which is the basis for your request for reasonable accommodation(s).

- 2) Which major life activity(s) is substantially limited by this disability?

- 3) Attach a copy of your current position description. Identify and describe the essential function(s) of your job which you are unable to perform without reasonable accommodation(s).

- 4) Identify and describe the reasonable accommodation(s) you believe is needed to enable you to perform the essential functions of your job properly and safely, including special equipment, changes in the physical layout of the job or other accommodations.

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- 5) Identify and describe any equipment, aids or services that you are willing to provide and utilize.

- 6) Identify the names, addresses and telephone numbers of physicians, therapists, psychologists or other health care providers who have information or documentation concerning your disability or your need for a reasonable accommodation.

DEFINITIONS

“DISABILITY” includes 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.

“MAJOR LIFE ACTIVITIES” are those basic activities that the average person in the general population can perform with little or no difficulty. They include functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

“ESSENTIAL FUNCTIONS” of a position are those fundamental job duties of the employment position - not the marginal functions. Functions may be essential for any of several reasons, for example, if they are the reason the position exists, only a limited number of employees perform them, if they are highly specialized, or the consequences of not performing them are significant.

“REASONABLE ACCOMMODATION” includes modification or adjustment to the job or work environment to enable a qualified individual with a disability to perform the essential functions of the job in question.

These definitions are provided only as a guide for completing this form. Nothing in this form is intended to alter the legal definitions of these terms or impose obligations on TESC not required by law.

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CONFIDENTIAL AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, have requested Reasonable Accommodation from my employer, The Evergreen State College.

I hereby authorize the Associate Vice President for Human Resource Service and/or his/her designated representative to receive medical information that will allow my employer to evaluate whether I have a disability and any limitations that affect my ability to enjoy an equal employment opportunity.

If this information includes medical information related to mental health issues, alcohol or drug treatment, or sexually transmitted diseases, I specifically authorize release of that information as indicated below:

- Mental Health Records (RCW 71.05)
- Alcoholism, Intoxication, and Drug Addiction (RCW 70.96A)
- Sexually Transmitted Diseases and HIV/AIDS (RCW 70.24)

I give permission for the use and disclosure of my confidential medical information solely on a need to know basis and solely for this stated purpose.

I understand that I may revoke or discontinue my authorization in writing at any time, and that revocation will not affect any information already shared.

A photocopy and/or fax of this release form will be valid as an original, even though the said photocopy and/or fax does not contain an original writing of my signature.

This authorization is valid for ninety (90) days from date of signature unless specifically revoked during this time.

Employee's Name (Please Print)

Employee's Signature

Date

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