Associate Request for Reasonable Accommodations
Thompson Health

Introduction

As an equal opportunity employer, Thompson Health is committed to taking affirmative action to employ and advance in employment qualified individuals with disabilities. This includes the commitment to make reasonable accommodations to the known physical or mental limitation of otherwise qualified individuals who seek employment at Thompson Health.

If you are seeking disability related workplace accommodations, you can submit a request for accommodation by supplying the information requested on this and the following pages and submitting it to Associate Services.

To request a disability related workplace accommodation, please follow these 3 steps.

1. Complete the following three items:
    a. Associate Information Form (bottom of this page)
    b. Health Care Provider Release Form (page 2) and
    c. Reasonable Accommodation Request Form (page 3)

2. Ask your health care provider to fill out the attached form "Request for Documentation to Certify Disability" (pages 4, 5 and 6).

3. Fax the completed forms to Associate Services at 585-396-6480.

Associate Information

Department: _____

Associate Name: _____

Address: _____

Job Title: _____

Supervisor: _____

Request Date: _____

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Health Care Provider Release Form

I _____, hereby authorize you to complete the attached Request for Documentation to Certify Disability, pages 4 and 5 of this packet, and to share with the Associate Services Department, Thompson Health and other Thompson Health representatives, as necessary, any records and/or information relating **only** to the condition(s) for which I am requesting disability related accommodations:

_____

(list the condition(s) for which you are requesting accommodations)

This form will be used for the purpose of evaluating my request for a disability related reasonable accommodation pursuant to the Americans with Disabilities Act As Amended and other federal, state or local laws that protect individuals with disabilities from discrimination.

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 this law. To comply with this law, I ask that you not provide any genetic information when in your responses to this request for medical information.

I understand that I have no obligation to disclose any information from my medical records, and all information disclosed pursuant to this Release shall be treated confidentially. I also understand that I may revoke this consent at any time by notifying you in writing of my decision. I have read this form or have had it read and explained to me and I understand its contents.

Associate Signature: _____ Date: _____

Name and Address of Health Care Provider:

_____
(name)

_____
(address)

_____
(address)

Phone Number: _____

Fax Number: _____

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Reasonable Accommodations Request Form

The purpose of this form is to assist Thompson Health in determining whether, or to what extent, a reasonable accommodation can be provided to allow you to perform the essential functions of your job safely and effectively.

We will confirm your medical condition with your provider, but ask that you answer the following questions to assist us in understanding the basis and nature of your request for an accommodation (attach additional sheets if necessary).

A. Please describe as completely and specifically as possible the accommodation(s) you are requesting.

_____
_____
_____
_____

B. In what ways does your disability impact your ability to perform specific functions of your job (i.e., what specific functions or duties are you unable to perform without an accommodation due to your disability and why)?

_____
_____
_____
_____

C. Please explain how you believe that the accommodations requested above will allow you to continue to perform the essential functions of your position.

_____
_____
_____
_____

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NOTE TO ASSOCIATE SERVICES: This form must be maintained and filed separately (under lock and key) from the associate's personnel file and be treated confidentially.

Request for Documentation to Certify Disability

(To be completed by a diagnosing Physician or Health/Mental Health Care Provider)

Associate Name: _____

The above is an associate of Thompson Health. The associate has requested a workplace accommodation due to a medical condition indicated to be disabling and has identified you as the treating physician. The associate believes that an accommodation is necessary to enable her/him to perform the essential functions of their job. Please answer the following questions, designed to assist Associate Services in evaluating this request and return the form to your patient. The information you provide will be confidential.

1. Have you examined the above mentioned associate in connection with the health condition(s) indicated on page 1 of this document?

   YES _____ NO _____

2. Is this person currently under your care for treatment of this health condition?

   YES _____ NO _____

3. Is this impairment temporary or permanent? _____

4. If the impairment is temporary, what is the expected duration of the impairment?

   _____

5. Does the impairment substantially limit a major life activity as compared to most people in the general population?

   YES _____ NO _____

   Note: Does not need to significantly or severely restrict to meet this standard. It may be useful in appropriate cases to consider the condition under which the individual performs the major life activity, or for which the individual can perform the major life activity.

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If *yes*, what major life activity(s) (includes major bodily functions) is/are affected?

- ☐ Bending
- ☐ Breathing
- ☐ Caring For Self
- ☐ Concentrating
- ☐ Eating
- ☐ Hearing
- ☐ Interacting With Others
- ☐ Learning
- ☐ Lifting
- ☐ Performing Manual Tasks
- ☐ Reaching
- ☐ Reading
- ☐ Seeing
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Walking
- ☐ Working
- ☐ Other: (describe)

Major bodily functions:

- ☐ Bladder
- ☐ Bowel
- ☐ Brain
- ☐ Cardiovascular
- ☐ Circulatory
- ☐ Digestive
- ☐ Endocrine
- ☐ Genitourinary
- ☐ Hemic
- ☐ Immune
- ☐ Lymphatic
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Normal Cell Growth
- ☐ Operation of an Organ
- ☐ Reproductive
- ☐ Respiratory
- ☐ Special Sense Organs & Skin
- ☐ Other: (describe)

6. Questions to help determine whether an accommodation is needed. An associate with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

    a. What limitation(s) is interfering with job performance or accessing a benefit of employment?

    b. What job function(s) or benefits of employment is the associate having trouble performing or accessing because of the limitation(s)?

    c. How does the associate's limitation(s) interfere with her/his ability to perform the job function(s) or access a benefit of employment?

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7. Questions to help determine effective accommodation options. If an associate has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

    a. Do you have any suggestions regarding possible accommodations to improve job performance?

    If so, what are they?

    b. How would your suggestions improve the associate's job performance?

8. Other questions or comments.

_____

_____

_____

_____

Provider Signature: _____ Date: _____

License # _____ State: _____

Print Name/Title: _____ Phone: _____

Address: _____

Thank you for taking the time to furnish this information on behalf of your patient. We will use the information you have provided to evaluate the associate's request for reasonable accommodation and will follow up should we have additional questions. Please return this form by e-mail, fax or mail to the address listed below.

Associate Services Benefits Administrator
350 Parrish Street, Canandaigua NY 14424
Johnpaul.Mlynar@thompsonhealth.com
(P) 585-396-6681 (F) 585-396-6480

[1]The Americans with Disabilities Act as Amended defines a physical impairment as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin and endocrine" and a mental impairment as "any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities." NYS Human Rights Law defines a disability as a physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions, which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques or a record of such an impairment or a condition regarded by others as such an impairment.