INFORMATION REGARDING REQUESTS FOR WORK OR WORKPLACE MODIFICATION

General Information

This packet contains information about the options available to an employee with a physical or mental condition that may require modification of work assignments of the workplace itself. The forms required to make specific modification requests are also included.

Forms Required

Workplace Modification Request

If you are a requesting a workplace modification that does not rise to the level of a request for accommodation under the ADA, you must complete the Workplace Modification Request.

ADA Reasonable Accommodation Request

If you believe that you have an ADA qualifying condition and are requesting reasonable accommodation subject to the ADA, you must complete the ADA Request for Accommodation.

Temporary Restricted Duty Request

If you are requesting a temporary reassignment to restricted, modified or limited duty rather than a long term or permanent accommodation, you must complete the Temporary Restricted Duty Request.

Employee Obligations

As the person requesting work assignment or workplace modifications, you are obligated to provide sufficient information to allow the employer to make a reasoned decision about what modifications, if any, should be made. This may require that you provide medical records or be evaluated by a professional health care provider.

STATE OF ALASKA DEPARTMENT OF CORRECTIONS

WORKPLACE MODIFICATION REQUEST

Complete this form if you are requesting a long term or permanent modification of the work environment in a situation, which does not rise to the level of an ADA qualifying event. Illustrative examples of workplace modifications include ergonomic or adaptive equipment such as a chair for a person with back problems or a keyboard for a person with repetitive stress injury to the wrists.

Employee Information

Name	Job Title	PCN
Department	Division	
Region/Section	Location	
Telephone	E-mail	
Supervisor's Name	Telephone	Fax

1. **Explain why you are making a request for a work modification.**

2. **If the request is the result of an on the work related illness or injury, have you applied for Worker's Compensation?**

3. **Describe the modification you are requesting, including (if known)**

4. **Explain how the work modification you are requesting will enable you to perform specific job tasks.**

5. **Explain the consequences of a denial of this request.**

______________________________ ________________________
Employee Name (Please Print) Work Telephone

______________________________ ________________________
Signature Date

Employee's Supervisor

1. Job functions discussed with employee: Date __________________________
2. Requested modification(s) discussed with employee: Date ________________
3. Recommendation: ____
____

____________________________________ ______________________________
Supervisor Name (Please print) Work Telephone

____________________________________ ______________________________
Signature Date

Approving Authority (as designated by agency policy)

1. Employee request: ☐ Approved ☐ Disapproved
2. Supervisor Recommendation: ☐ Approved ☐ Disapproved
4. Other modification approved: ____

____________________________________ ______________________________
Approving Authority/Title (Please Print) Work Telephone

____________________________________ ______________________________
Signature Date

CC: Department ADA Coordinator
Department Human Resources Manager

WORKPLACE MODIFICATION REQUEST

Documentation in Support of Request: Employee Release

I hereby authorize ______________________________ to provide the medical information requested by my employer. The information will be used to evaluate my request for a work modification.

______________________________	______________________________
Employee Name (Please Print)	Work Telephone
______________________________	______________________________
Signature	Date

Attachment: Letter from employing agency requesting provider information

TEMPORARY RESTRICTED DUTY REQUEST

Documentation in Support of Request: Employee Release

I hereby authorize ___________________________________ to provide the medical information requested by my employer. The information will be used to evaluate my request for temporary restricted duty.

______________________________	______________________________
Employee Name (Please Print)	Work Telephone
______________________________	______________________________
Signature	Date

Attachment: Letter from employing agency requesting provider information.

ADA REASONABLE ACCOMMODATION REQUEST

To be eligible for a reasonable accommodation under the Americans with Disabilities Act (ADA), you must (1) be qualified to perform the essential functions of your position and (2) have a qualifying disability that limits a major life function. A detailed explanation of the rights and obligations of employees under the ADA is contained in *The Americans With Disabilities Act: you Employment Rights as an Individual with a Disability,* which is available from your supervisor, the department Human Resource Office, or the State ADA Coordinator's Office in the Department of Labor and Workforce Development.

In order to complete this form, you will need to discuss the essential functions of your job with your supervisor. You may also contact your Division or Department ADA Coordinator or your department's Human Resources Manager if you have questions or need information about the ADA or the process for requesting reasonable accommodation.

Employee Information

Name	Job Title PCN
Department	Division
Region/Section	Location
Telephone	E-mail
Supervisor's Name	Telephone Fax

1. Describe your disability and how it limits a major life function(s)?

2. Describe any mitigating measures (medication, assistive technologies such as wheelchairs, etc.) you are using because of the disability, and the effect of those measures on the disability.

3. **Describe how the disability limits your ability to perform the essential functions of your job. Identify the essential functions of your job. Identify the essential functions affected and be specific about how the disability impairs your ability in each instance.**

4. **Describe the accommodation you are requesting.**

5. **Explain how the accommodations you are requesting will enable you to perform the essential functions of your job. Be specific.**

6. **Will you be able to perform all of the essential functions of your job if you receive the requested accommodation? If not, describe specific functions you will not be able to perform.**

7. **Do you need assistance to identify accommodations that will enable you to perform the essential functions of your job? If you do, explain what type of assistance you need.**

8. **Provide any information or suggestion you can on how the requested accommodation(s) can be provided. If known, include the names, addresses, and telephone numbers of vendors and the model number and approximate cost of any equipment requested.**

_______________________________ _______________________

Employee Name (Please Print) Work Telephone

_______________________________ _______________________

Signature Date