

State of Maryland
Reasonable Accommodation Request Form
CONFIDENTIAL

Employee or Applicant Name:	Job Title:
Daytime Phone #	Address:
Employee: <input type="checkbox"/> Applicant: <input type="checkbox"/>	Request Date:
My disability/functional limitation is:	
My disability/functional limitation prevents me from performing the following activities:	
I am requesting accommodation because: <input type="checkbox"/> I am applying for employment and the accommodation will allow me to participate in the application/selection process <input type="checkbox"/> I am currently employed by the State and require an accommodation in my current position.	
The accommodation I am requesting is: (Describe the type of accommodation, suggestions for work site or exam site modifications or specific job duties that may be restructured to facilitate your employment or participation, and the details of how or where the accommodation (if purchasable) may be obtained, including the cost if known)	
This accommodation will allow me to perform the functions of my job or participate in the application/selection process as follows: (Describe how the accommodation will assist you)	
<input type="checkbox"/> I UNDERSTAND THAT I MAY BE REQUIRED TO PROVIDE MEDICAL INFORMATION FROM MY HEALTH CARE PROVIDER AS PART OF THIS PROCESS.	
Signature:	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Print Name:	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>

MEDICAL INQUIRY FORM – REASONABLE ACCOMMODATION REQUEST

*To be completed by Health Care Provider (Confidential)

RETURN COMPLETED FORM TO: DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES OEEA ADA Coordinator, 6776 REISTERSTOWN ROAD, SUITE 306, Baltimore, MD 21215; Phone: 410-585-3005 Fax- 410-318-8905

NOTE: 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, 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.

Employee's Name _____ Job Title _____

A. QUESTIONS TO HELP DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY

A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. The following questions may help determine whether an employee has a disability:

Does the employee have a physical or mental impairment? Yes No

What is the impairment/diagnosis? _____

Is the impairment long-term or permanent? Yes No

If not permanent, how long will the impairment likely last? _____

Does the impairment affect a major life activity? Yes No

If yes, what major life activity(ies) is/are affected?

- | | |
|--|--|
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Breathing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Thinking | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Performing Manual Tasks |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Seeing |
| <input type="checkbox"/> Learning | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Working | |
| <input type="checkbox"/> Bending | |
| <input type="checkbox"/> Hearing | |
| <input type="checkbox"/> Lifting | |
| <input type="checkbox"/> Standing | |
| <input type="checkbox"/> Interacting with Others | <input type="checkbox"/> Other: _____ |

EMPLOYEE'S NAME _____

Is the employee substantially limited in one or more of these major life activities? Yes No

B. QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Which of the major life activities selected are interfering with the employee's ability to perform the job functions?

What job function(s) is the employee having trouble performing because of the limitation(s)?

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

C. QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Please state any suggestions regarding possible accommodations to improve the employee's ability to perform his/her job.

How would your suggestions improve the employee's ability to perform the job functions?

D. ADDITIONAL COMMENTS

Physician's Name *(Please Print)*

Physician's Signature: _____ **Date:** ____/____/____

Phone: _____ **Fax:** _____

Physician's Checklist
for
Essential Duties of Parole and Probation Supervisory Positions

Name of Employee: _____

SS#: _____ Unit: _____

Individuals employed as Parole and Probation Field Supervisor I or II; or Monitor Supervisor I or II positions must be able to perform the following essential duties.

IS THE INDIVIDUAL CAPABLE OF PERFORMING THE FOLLOWING DUTIES?

- | | | | |
|----|---|-----|----|
| 1. | Sit at a desk and communicate with employees, the public and members of the criminal justice community. Gather information by way of letters, telephone, electronic mail, or in-person interviews and respond to inquiries in a timely fashion. | YES | NO |
| 2. | Prepare reports in an electronic format using a personal computer with a keyboard or other electronic technology. Utilize a full range of computer software requiring navigation from one program or data source to another. | YES | NO |
| 3. | Organize and delegate work to assigned employees by reading documents in hard or soft copy and determining the type of work and equitable distribution of work among staff. Give clear directions and instructions to staff and listen and respond to questions either verbally or in writing in a timely fashion. | YES | NO |
| 4. | Read reports, letters, case notes and case files of assigned employees, and Make written notes of performance and or any incidents and maintain them in a working file for each employee. Effectively communicate the results of evaluations to direct-reports, which are logically based on employee observation and knowledge of Agency policy and procedure and standards for performance. | YES | NO |
| 5. | Efficiently analyze tasks to be performed, prioritize work assignments, and organize personal schedule to so that all routine duties and special assignments are completed in accordance with Agency standards and guidelines. | YES | NO |
| 6. | Maintain concentration and focus on each task until completed. | YES | NO |

Physician's Comments: _____

Name of Physician: _____ Date: _____

Address: _____

Telephone #: _____

Physician's Name Printed: _____