MECKLENBURG COUNTY
ADA ACCOMMODATION REQUEST PACKET

Employees who seek an accommodation have the responsibility to make the request and provide reasonable documentation and adequate information for the need of an accommodation. Completion of this is voluntary; however, failure to provide information may result in a denial of your request. The enacting of an accommodation does not imply that Mecklenburg County regards or considers an employee disabled. All information relating to an accommodation request, including medical documentation and this form, shall be maintained in a separate file; it shall be treated as confidential medical records with access limited to those who need to be informed including, but not limited to directors/managers/supervisors, legal counsel, human resources, and government officials investigating compliance issues.

Please be advised, we may need medical documentation to determine whether you have an impairment and whether that impairment substantially limits one or more major life activities. This documentation must come from an appropriate health care or rehabilitation professional, which includes but is not necessarily limited to, a doctor (including a psychiatrist), psychologist, nurse, physical therapist, occupational therapist, speech therapist, vocational rehabilitation specialist, and licensed mental health professional.

If you are a qualified individual with a disability, as defined under the ADA, Mecklenburg County maintains the right to choose the appropriate accommodation, if any, if it is medically necessary, and can be provided without constituting an undue burden upon the county.

Once your application has been received, reviewed, and approved by your department, you will be notified of your accommodation status. Approval of ADA paperwork does not automatically qualify you for Family and Medical Leave (FMLA). If you wish to use FMLA you must contact the Employee Services Center at (704) 432-6947.

Enclosed are the documents needed to request an accommodation under the Americans with Disability Act (ADA).

If you have questions, please contact HR Compliance at (980) 314-2777 or via email at HR.Compliance@mecklenburgcountync.gov.

Thank you,

Human Resources Policy & Compliance

Mecklenburg County
ADA Accommodation Request Form

Please Indicate: ☐ Employee ☐ Applicant

Please print or type

EMPLOYEE/APPLICANT INFORMATION:		
Name: (First, Middle Initial, Last)	**Employee Number:**	**Phone Number:**
Street Address:	**City, State, Zip**	
Email:	**Current Position/Position Applied for:**	
Department:	**Supervisor:**	

Type of Accommodation being requested:

☐ Medical ☐ Ergonomic ☐ Religious

Employee/Applicant please provide information about the accommodation that you are requesting. In your answer please provide clarified and detailed responses.

MEDICAL ACCOMMODATION REQUEST: (Must submit Medical Certification Form)
1. **What specific accommodation are you requesting?**
2. **If you are unsure of what form of accommodation is needed, please indicate whether you may have some suggestions as to possible options to explore.**
3. **Is your request time sensitive? ☐ Yes ☐ No** **If yes, please explain:**
4. **Is your request for an accommodation ☐ Temporary ☐ Permanent?** **If temporary, please indicate length of time:**
5. **What, if any essential job function(s) are you having difficulty performing? (Employee)**

Disclosure: The information disclosed on this request shall remain confidential and shall only be used in connection with employment decisions consistent with the provisions outlined under the ADA.

6. **What, if any employment benefit(s) are you having difficulty accessing? (Applicant)**

7. **What limitation is interfering with your ability to perform your job or accessing any employment benefit(s)?**

8. **If you are requesting a specific accommodation, how will that accommodation assist you in performing your job functions you are having difficulty performing or the employment benefit you are having difficulty accessing?**

9. **Please provide any additional information, which you believe will be helpful in processing your accommodation request.**

ERGONOMIC ACCOMMODATION REQUEST:

1. **What specific accommodation are you requesting?**

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

3. **Is your request for an accommodation ☐ Temporary ☐ Permanent?**
   If temporary, please indicate length of time:

RELGIOUS ACCOMMODATION REQUEST:

1. **What specific accommodation are you requesting?**

I authorize the release of necessary confidential medical information from my physician to the Department of Human Resources as medically necessary. I certify that the information provided on this form is true. I understand that making false statements on this form is grounds for corrective action up to and including termination.

Signature: _____ Date: _____

RETURN FORM TO:

Mecklenburg County
Department of Human Resources
Policy & Compliance
HR.Compliance@mecklenburgcountync.gov

Disclosure: The information disclosed on this request shall remain confidential and shall only be used in connection with employment decisions consistent with the provisions outlined under the ADA.

ADA requests will be reviewed for completeness if further information is needed for clarification you and/or your doctor will be contacted for more information. Please allow up to 10 business days from the time all documentation is received for a response.

HR COMPLIANCE USE ONLY		
Request Received:	Medical Response Received:	Employee Contact Required: ☐ Yes ☐ No
Interactive Process Begins:		Request Approved: ☐ Yes ☐ No
Notification sent to Employee:		Compliance Signature:

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Mecklenburg County
Medical Certification for an ADA Accommodation Request Form

Employee: Your healthcare provider should return this form to the Department of Human Resources, Compliance Office, within **five (5) working days** from his/her receipt of this document. If circumstances will not permit him/her to return this form within the proscribed timeframe, please contact the Compliance Office immediately.

Before providing this document to your provider please ensure you attach a copy of your Job Description. Job Descriptions can be found on MeckWeb under Class & Compensation or by clicking here Job Descriptions.

Information obtained on this form pertains only to the condition for you are requesting accommodation under the Americans with Disability Act (ADA).

TO BE COMPLETED BY EMPLOYEE:		
Employee Name: (Last Name, First Name, Middle Initial)	**Date of Birth:**	**Employee Number:**
Job Title:	**Department:**	
I authorize my medical provider(s) to release the following information from my patient file to Mecklenburg County for the purpose of exploring coverage and reasonable accommodations under the Americans with Disabilities Act.		
Employee Signature:		**Date:**

Medical Provider: For a reasonable accommodation under ADA, an employee must have a disability or an impairment that substantially limits one or more major life activities or a record of such impairment. The following questions may help to determine whether the employee has a disability.

Please answer the following questions based on what limitations the employee has when his/her condition is in an active state AND what limitations the employee would have if no mitigating measures were used. Mitigating measures include, but are not necessarily limited to, medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. However, mitigating measures do not include ordinary eyeglasses or contact lenses.

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:	
Instructions: Attached is a copy of the employee's job description which indicates the essential functions of the position and includes the physical/mental demands and environmental conditions associated with the job. Please review the job description then complete and sign this form.	
Physician Name:	
Address:	**Specialization/Type of Practice:**
Phone Number:	**Fax Number:**

Disclosure: The information disclosed on this request shall remain confidential and shall only be used in connection with employment decisions consistent with the provisions outlined under the ADA.

Questions to help determine whether employee has a qualifying disability. A person has a qualifying disability under ADA if the person has an impairment that substantially limits one or more major life activities.

1. **Does the employee have a physical or mental impairment?** ☐ Yes ☐ No
   a. If yes, what is the impairment or nature of the impairment?

2. **Does the impairment substantially limit a major life activity as compared to most people in the general population?** ☐ Yes ☐ No

3. **Is the impairment permanent?** ☐ Yes ☐ No
   a. If not permanent, how long will the impairment last? _____

4. **Is this a condition which?**
   a. Requires periodic visits for treatment by a healthcare provider. ☐ Yes ☐ No
   b. Continues over an extended period of time. ☐ Yes ☐ No
   c. May cause episodic rather than a continuing period of incapacity? ☐ Yes ☐ No
   d. Is the patient taking medications or treatments that would be expected to affect job performance, or would pose a direct threat or safety risk? If yes, please explain.
      ☐ Yes ☐ No

5. **Does the impairment affect a major life activity?** ☐ Yes ☐ No

What major life activity and/or bodily functions are affected? Check all that apply.

☐ Bending	☐ Eating	☐ Neurological	☐ Thinking
☐ Bladder	☐ Genitourinary	☐ Operation of organ	☐ Walking
☐ Bowel	☐ Hearing	☐ Reaching	☐ Working
☐ Brain	☐ Hemic	☐ Reading	☐ Other: _____
☐ Cardiovascular	☐ Immune	☐ Reproductive	
☐ Caring for Self	☐ Interacting w/others	☐ Respiratory	
☐ Circulatory	☐ Learning	☐ Seeing	
☐ Concentration	☐ Lifting	☐ Sitting	
☐ Digestive	☐ Lymphatic	☐ Sleeping	
☐ Driving	☐ Musculoskeletal	☐ Standing	

Comments:

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Questions to determine whether an accommodation is needed. An employee with a disability is entitled to an accommodation ONLY when the accommodation is needed because of the disability. The following questions will help to determine whether the requested accommodation is needed because of the disability.

1. What limitation(s) are interfering with the employee's ability to perform his/her job or accessing an employment benefit?

2. What job function(s) or benefit(s) of employment is the employee having difficulty performing or accessing because of the limitation(s)?

3. How does the employee's limitation(s) interfere with his/her ability to perform the essential job functions or access a benefit of employment?

Questions to determine whether an accommodation is needed. Mecklenburg County must provide a reasonable accommodation to an employee who needs an accommodation because of the disability unless that accommodation poses an undue hardship. The following questions will help in determining an effective accommodation.

1. Do you have any suggestions regarding possible accommodations? If so, please explain.

2. How would your suggestion(s) improve the employee's job performance and/or ability to access employment benefits?

3. Additional comments/concerns:

Signature of Healthcare Provider:	**Date:**

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE RETAINED IN THE EMPLOYEE'S MEDICAL FILE.

RETURN FORM TO:

Mecklenburg County
Department of Human Resources
Policy & Compliance
FAX: (888) 301-6024
HR.Compliance@mecklenburgcountync.gov

Disclosure: The information disclosed on this request shall remain confidential and shall only be used in connection with employment decisions consistent with the provisions outlined under the ADA.