City of Brownsville
Request for Reasonable Accommodation Packet
Human Resources
1001 E. Elizabeth St, 4th Floor, Brownsville, TX 78521
Phone: 956.548.6037/Fax: 956.546.2429

EMPLOYEE INSTRUCTIONS:

1. Complete Section I of the Reasonable Accommodation Request form (pgs. 2-3).

- Give your Department Section II, Job Description and Essential Function Analysis (pgs. 4-6) for its completion.
- Answer all the questions/fill in all the blanks.
- DO NOT state your medical condition or diagnosis.
- Provide all of your current contact information.
- Note that incomplete information may cause a delay in processing your request.
- It is highly encouraged that you to fill out and sign the Authorization to Release Medical Records (pg. 7).

2. After completing the Section I ensure that your department has completed Section II, Job Description and Essential Function Analysis. Section II will need to be submitted with the Request for Medical Information Form (pgs. 8-9) along with your Job Description to your Health Care Provider and ask him/her to complete the Health Care Provider section. If your Department does not have your Job Description, have them contact our offices.

3. Return all completed forms to via email, fax or hand delivered to:

City of Brownsville
Human Resource
1001 E. Elizabeth St
4th Floor
Brownsville, TX 78521
Email: hr@cob.us
Fax: 956.546.2429

4. You will be notified by Human Resources whether your medical condition qualifies under the law, making you eligible for accommodation, and advised of next steps in the process.

5. Contact HR if you have questions by Phone: 956.548.6037, or via the E-mail address above.

HEALTH CARE PROVIDER INSTRUCTIONS:

1. Complete the Request for Medical Information section:

- Type or print legibly and sign. Incomplete forms or illegible information may cause a delay in your patient/our employee receiving a Reasonable Accommodation.
- Note that your patient/our employee has signed an authorization for the release of this information. All information is held strictly confidential in accordance with relevant laws and regulations.

2. Return completed forms either to your patient or to the City of Brownsville Human Resources Office using the contact information above.

THANK YOU FOR YOUR COOPERATION!

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Reasonable Accommodation Request form

CONFIDENTIAL

This form should be used by City of Brownsville employees who believe they have a disability and wish to request a reasonable accommodation under the Americans with Disabilities Act (ADA) and the Americans with Disabilities Amendments Act (ADAAA) or other applicable State and Federal civil rights laws. By accepting this request, City of Brownsville does not consider or regard the person as having disability as defined by the ADA, the Texas Workforce Commission on Human Rights Act (TCHRA), or any other applicable law. If additional space is needed to fully answer a question, please attach a separate sheet of paper. If you need assistance completing this for or any part of the reasonable accommodation process, please contact our office. Please keep a copy for your records. The purpose of this form is to assist the City of Brownsville in determining whether, or to what extent, a reasonable accommodation is appropriate for a qualified City employee. This form will be filed separately from the employee's personnel file and is a **confidential** document.

SECTION I: To be completed by Employee

Name: _____ Telephone: _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Email Address: _____

Job Title/Classification: _____

Supervisor's Name: _____ Telephone: _____

Department/Division: _____ Request Date: _____

Please complete

1. Identify your physical and/or mental impairment(s) for which you are requesting an accommodation and expected duration of the impairment(s).

_____

_____

_____

_____

_____

_____

2. Explain how the impairment(s) listed on question 1 affects your ability to perform the essential function(s) of your job.

_____

_____

_____

_____

_____

_____

3. List the accommodation(s) you are requesting in order to perform your essential job functions (attach additional pages if necessary).

_____

_____

_____

_____

_____

_____

4. Medical verification of impairment (check the appropriate box):

☐ I have enclosed the applicable medical documents with this request.

☐ The disability and the need for a reasonable accommodation is obvious and no medical documentation is needed. Explain

_____

_____

_____

_____

_____

_____

I, _____ , give the City of Brownsville, permission to explore coverage and reasonable accommodations under the ADAAA, and all applicable State and Federal laws. I understand that all information obtained during this process will be maintained and used in accordance with the ADA, including its confidentiality requirements.

_____ _____

Signature of Requestor Date

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 employees or their family members. In order 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 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 members sought or received genetic services and genetic information of a fetus carried by an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services

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Section II: To be completed by Department

JOB DESCRIPTION AND ESSENTIAL FUNCTION ANALYSIS

Please complete this form immediately and return it to the Employee along with their respective Job Description to give to their Medical Provider with the Request for Medical Information Form

.

(PLEASE PRINT)

Director or Supervisor completing this form: _____

Job Title: _____ Department: _____

Employee Requesting Accommodation Name/Title: _____

ESSENTIAL JOB RESPONSIBILITIES

List the job's essential responsibilities. A job function is essential if the position requires the employee to perform the function and if removing the function fundamentally alters the position. There are typically no more than five major responsibilities. Also indicate the approximate percent of time spent on each job function. Please attach a copy of the employee's job description.

#	Responsibility	% of Time
1		
2		
3		
4		
5		

1. Does this position exist to perform some or all of these functions?

_____

_____

2. Can these functions be performed by other employees in the department?

_____

_____

3. Would taking any or all of these functions from the job fundamentally change the job?

_____

_____

4. Would there be significant consequences if any of these functions are not performed? Please explain.

_____

_____

5. Did the incumbent of this position perform these functions?

_____

_____

6. Is expertise or judgment required? Please explain.

7. Is special training or education required? Please explain.

8. Is a license or certification required? Please explain.

ESSENTIAL FUNCTION ANALYSIS

Please complete the following items based on an evaluation of the position. NOTE: In terms of an 8-hour workday, check the appropriate box for each of the following items which most accurately describe the extent of the specific activity performed by this employee on a daily basis.

N = Never; O = "Occasionally" equals 1% to 33%; F = "Frequently" equals 34% to 66%; C = "Continuously" 67% to 100%

COGNITIVE REQUIREMENTS

	N	O	F	C		N	O	F	C
Thinking analytically					Examining/observing details				
Using effective verbal communication					Making decisions and meeting priorities				
Handling stress & Emotions					Adjusting to changes				
Establishing effective interpersonal relationships					Meeting deadlines and following up on assignments				

PHYSICAL REQUIREMENTS

Must relate to the performance of tasks and responsibilities of the job, and be consistent with business necessity.

	N	O	F	C		N	O	F	C
Standing & walking					Bending/twisting				
Lifting & carrying					Repetitive use of hands/arms				
Pushing & pulling					Repetitive use of legs				
Climbing					Keyboarding				
Speech/Hearing					Sight				

PERFORMANCE REQUIREMENTS

	N	O	F	C		N	O	F	C
Attending work related meetings					Writing				
Working effectively with co-workers					Operating Equipment/Motor Vehicle				
Directing or Supervising others					Maintaining health and safety standards				

*Please complete the next section **only if applicable.***

SUPERVISORY RESPONSIBILITIES

Complete the following table for positions supervised as a part of this job function.

Position Title	Hours per week	Employment Type

Explain what authority and responsibility the position has regarding hiring, evaluation, discipline, leave use, and/or termination of the employees supervised.

My signature denotes that this position is an accurate and correct statement of the duties, responsibilities, and functions assigned to this position.

Supervisor's Signature

Date

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Authorization to Release Medical Records

INSTRUCTION FOR EMPLOYEE: Complete patient information, health care provider information and sign authorization release below. Make additional copies of this form for each of your health care providers, if you have more than one.

Section A: Individual for whom medical records are being requested.

First Name:_____ Middle Name:_____ Last Name:_____

Previous Name (if applicable):_____ Date of Birth:_____

Street Address:_____ City/State/Zip:_____

Daytime telephone number(s):_____

Section B: Person or organization from whom medical records are requested.

Hospital/agency/clinic/physician:_____ Attention:_____

Street Address:_____ City/State/Zip:_____

Phone:_____ Fax:_____

Section C: Information to be disclosed from DATE (or RANGE OF DATES) Dates(s):_____

Check information needed.

- ☒ History and Physical
- ☐ Physician's Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Social History
- ☐ Behavior Plans
- ☐ Other (explain) _____

Section D: Purpose of Disclosure. Check reason(s) for the release of medical information.

To determine eligibility or program requirements for:

- ☒ Accommodation Request
- ☐ Other (explain)_____

Section E: Signature

I have requested an accommodation from City of Brownsville under The Americans with Disability Act (ADA) of 1990. I hereby authorize the ADA Coordinator for the City of Brownsville to communicate directly with the health care provider listed on this form, in order to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation. This authorization will automatically end within 30 days from the date I sign this form

a) The City of Brownsville will provide specific information about my job position including the essential functions and specific requirements.
b) All information obtained from employee medical examinations and inquiries will be job-related and consistent with business necessity.
c) All information obtained will be maintained and used in accordance with the Americans with Disability Act (ADA) or other applicable State and Federal civil rights laws.

Signature of Employee:_____ Date:_____ (mm/dd/yyyy)

After signing and completing this form, all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as the term is defined by HIPPA and Texas Health & Safety Code § 181.001 must obtain signed authorization from the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPPA, the Texas Medical Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

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REQUEST FOR MEDICAL INFORMATION FORM

INSTRUCTIONS FOR MEDICAL PROVIDERS
Your patient has requested that the City of Brownsville Human Resources Department provide him/her with a reasonable accommodation/modification in order to perform their essential duties with ease. Please provide a detailed description of the specific physical and/or mental condition(s) that affects the patient's ability to perform certain tasks and engage in certain activities, any reasonable accommodation/modification needed and the relationship between the accommodation/modification and the patient's impairment. You may attach additional medical information to the forms as needed. **Please return this completed form to the patient.**

Name of Patient (Please Print):_____ **Date of Birth**:_____

Name of Medical Provider:_____

Address of Medical Provider:_____

Telephone Number of Medical Provider:_____

1. Please state patient's medical and/or mental health condition(s):

_____

_____

_____

_____

_____

_____

_____

2. Please provide a detailed description of the specific physical and/or mental health restrictions/limitations affecting the patient's ability to perform certain tasks and engage in certain activities. Please describe how the impairment affects the patient's work tasks.

_____

_____

_____

_____

_____

_____

_____

3. Indicate whether the patient's condition(s) is permanent, chronic, episodic or temporary. If the patient's condition(s) is temporary, please state its anticipated duration.

4. Please describe the reasonable accommodation/modification needed by the patient and the relationship between it and client's medical and/or mental health conditions.

5. Does the patient's physical and/or mental health condition(s) make it difficult for the patient to perform the activities on the JOB DESCRIPTION AND ESSENTIAL FUNCTION ANALYSIS FORM: (Fully describe the difficulties the patient has for each checked box):

Signature of Medical Provider

Date

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SECTION III: To Be Completed by Human Resources Department

1. Has the employee completed Section I? ☐ Yes ☐ No
If no, ensure that employee complete Section I.

2. Has Section II, Essential Job Function Analysis been completed? ☐ Yes ☐ No
If no, ensure the department has completed the analysis.

3. Has the Authorization to Release Medical Records been completed? ☐ Yes ☐ No
If no, ensure employee to complete.

4. Has Request for Medical Information Form been complete? ☐ Yes ☐ No
If no, ensure employee completes form.

Accommodation Request is: ☐ Approved ☐ Denied ☐ Modified

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed by:

Name: _____ Title: _____

Telephone Number: _____ Date: _____

Email: _____

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 employees or their family members. In order 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 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 members sought or received genetic services and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services