Diagnosed with a Disability?

If you have been diagnosed with a disability, you may be concerned as to how you will manage in your job. Let us know about your concerns because under the Americans with Disabilities Act (ADA) you can request accommodations that may help you to do your job. In this document you will find the following three forms that need to be completed to begin this process:

- **Employee Request for AccommodationForm**
  To be completed by you, the employee
- **Documentation of Disability Form**
  To be completed by the diagnosing professional
- **Functional Limitations Form**
  To be completed by the diagnosing professional

Return the completed forms to the Human Resources office to determine if your disability qualifies for accommodations under the American with Disabilities Act (ADA). You will be contacted once a determination has been made. If the disability qualifies for accommodations under ADA, options will be explored to determine reasonable and suitable accommodations which meet the needs of the you, the individual, and the department.

The Town of Amherst offers employees a free Employee Assistance Program (EAP). The EAP is a voluntary program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees and their family members who might be experiencing stress or adjustment issues. If you feel that you or your family might benefit from the assistance of our EAP during this time, please contact the EAP, AllOne Health, 24 hours a day, 7 days a week at 1-800-451-1834.

If you have any further questions, please contact Human Resources at 413-259-3119.

American with Disabilities Act

Employee Request for Accommodation

This form must be completed when an employee is requesting an accommodation due to a documented disability. To be eligible for a reasonable accommodation under the Americans with Disabilities Act (ADA), you must be qualified to perform the essential functions of your position with or without an accommodation, and have a qualifying disability that limits a major life function.

Employee Name:_____ Employee Phone: _____

Manager:_____ Manager Phone: _____

Department:_____ Date:_____

1. Please describe which major life activity your impairment limits. (For example: caring for oneself, performing manual tasks, walking, seeing, hearing, sitting, speaking, breathing, learning, remembering, concentrating, etc.)

2. Using your job description, describe how your condition limits your ability to perform the essential functions of your job. Be specific about how the medical condition impairs your ability in each instance.

3. Specifically describe the accommodation(s) you are proposing.

4. Please add any comments you feel may be helpful in our consideration of your request:

Employee's Signature:_____ Date:_____

Diagnosing Professional's Documentation of Disability

As part of the accommodation process, documentation that an employee has a qualifying disability is required. The ADA defines a qualifying disability as one that fits into one of these categories.

- A physical or mental impairment that substantially limits one or more major life activities;
- A record of impairment
- Regarded as having an impairment

This form is designed to provide a method for compliance with this mandate for documentation and should be completed by the employee's diagnosing professional.

Employee Name:_____ Employee Phone:_____

Diagnosing Professional:_____ Phone:_____

Professional's Title: _____

Professional's License #:_____ Date: _____

1. Using the space below or by attaching a letter, please describe the diagnosis and how it fits into one of the categories above.

2. Please suggest accommodations relating to the above diagnoses (if any)

Professional's Signature:_____ Date:_____

FunctionalLimitationsFormtobecompletedbythe diagnosing professional

- **Please review Essential Job Functions described on the attached Job Description.**

- **What major life activity(s) is/are affected? (Please check all that apply.)**

o Bending	o Interacting with Others	o Seeing	o Walking
o Breathing	o Learning	o Sitting	o Working
o Caring for Self	o Lifting	o Sleeping	o Other (Describe):
o Concentrating	o Performing Manual Tasks	o Speaking	
o Eating	o Reaching	o Standing	
o Hearing	o Reading	o Thinking	

Please describe the Limitation related to the Major Life Activity:

_____

_____

_____

_____

- **Major Bodily Functions: (Please check all that apply)**

o Bladder	o Cell Growth	o Immune	o Digestive
o Endocrine	o Brain	o Reproductive	o Musculoskeletal
o Neurological	o Hemic	o Circulatory	o Special Sense
o Bowel	o Operation of an Organ	o Lymphatic	o Organs
o Genitourinary	o Cardiovascular	o Respiratory	o Other:

Please describe the Limitation related to the Major Bodily Function:

_____

_____

_____

_____

- **Duration: Describe the nature, severity and anticipated duration of impairment.)**

Temporary (explain):_____

Anticipated duration: _____

Temporary with residual side effects (explain):_____

Permanent (explain): _____

Chronic (explain): _____

Functional Limitations Form to be completed by the diagnosing professional *(continued)*

o **Mental, Emotional, and Sensory Limitations (Please check all that apply.)**

o Pace of Work	o Frequent Change	o Reasoning	o Verbal Communication
o Manage Multiple Priorities	o Short-term Memory	o Hearing	o Written Communication
o Intense Customer Interaction	o Long-term Memory	o Reading	o Vision
o Multiple Stimuli	o Attention Span	o Analyzing	

Please describe the Limitation and severity related to the Mental, Emotional, or Sensory Limitation:

_____

_____

_____

_____

Additional Comments from Diagnosing Professional:

_____

_____

_____

_____

Are the above limitations permanent?

o Yes o No

If not, please comment on anticipated duration:

_____

_____

_____

_____

Print Professional's Name: _____

Professional's signature: _____

Professional's License #: _____

Date: _____ Office Phone #: _____