Prescribed by: AI 114

CONFIRMATION OF REQUEST FOR REASONABLE ACCOMMODATION

OMB No. 0704-0498
OMB approval expires: 20220930

INSTRUCTIONS

This form should be completed whenever an employee or applicant requests an accommodation. For additional information or assistance in completing this form, please call the WHS/DDR Reasonable Accommodation Program Manager (RAPM). Upon completion of the form, please provide a copy to the deciding official, i.e., supervisor or other designee and a copy to the RAPM.

You may be asked to provide medical information in support of your accommodation request. Under the Rehabilitation Act, any medical information obtained in connection with the reasonable accommodation process must be kept confidential and can only be disclosed to and by authorized parties in accordance with the Privacy Act. All medical information obtained in connection with a request for reasonable accommodation must be kept in files separate from the individual's personnel file and secured when not in use by the authorized parties. This includes the fact that an accommodation has been requested or approved and information about functional limitations. It also means that any employee who obtains or receives such information is strictly bound by these confidentiality requirements. For more information, please see the text of the Privacy Act of 1974 (5 U.S.C. 552a), as amended, http://www.justice.gov/opcl/privstat.htm, and the OPM regulations on the Employee Medical File Systems of Records, OPM GOVT-10.

1. APPLICANT OR EMPLOYEE

a. NAME *(Last, First, Middle Initial)*	b. TELEPHONE NUMBER *(Commercial or DSN)*

c. EMPLOYEE'S ORGANIZATION

2. TODAY'S DATE *(YYYYMMDD)*	**3. DATE OF REQUEST** *(YYYYMMDD)*

4. ACCOMMODATION REQUESTED *(Be as specific as possible, e.g., adaptive equipment, reader, interpreter.)*

5. REASON FOR REQUEST

6. IF ACCOMMODATION IS TIME SENSITIVE, PLEASE EXPLAIN

Return form to Reasonable Accommodation Program Manager.

7. LOG NUMBER *(Assigned by Reasonable Accommodation Program Manager)*

PRIVACY ACT STATEMENT

AUTHORITY: 29 U.S.C. 791, 42 U.S.C. Chapter 126, 29 CFR Part 1630, E.O. 13163, E.O. 13164, and DoD Directive 1020.1.
PRINCIPAL PURPOSE(S): To document requests for reasonable accommodation(s) (regardless of type of accommodation) and the outcome of such requests for employees of Washington Headquarters Services/Human Resources Directorate serviced components with known physical and mental impairments and applicants for employment with Washington Headquarters Services/Human Resources Directorate serviced components. These records are covered by SORN DWHS P49: http://dpclo.defense.gov/privacy/SORNs/component/osd/DWHSP49.html and Privacy Impact Assessment http://www.whs.mil/EITSD/PrivacyImpactAssessments.cfm.
ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html apply to this collection.
DISCLOSURE: Voluntary. However, failure to provide sufficient information may delay or prevent an adequate basis to determine an appropriate accommodation.

Employees may use this fillable template to provide information to the Disability Program Manager as part of the request process. Employees are not required to use the template, but each employee requesting an accommodation exception (to a return to work order) will be asked to provide the information during the process, in one form or another. The template is provided as a convenience to employees to help facilitate their request.

DoDEA Covid-19 Request for Exception to a Return to Work Order - Info Template

INSTRUCTIONS: The employee completes the first page. A treating medical professional completes the second page. The employee should submit both pages, completed in full and appropriately signed, to their first-line supervisor. Attach additional pages as needed. Please do not send copies of medical records; if medical records are necessary, we will request them separately.

Employee's Name: _____

Telephone number: _____

Duty Location: _____

Supervisor: _____

☐ I certify that I have viewed the CDC Guidance on high-risk and that I have one of the conditions, identified below, that puts me at greater risk of severe illness from COVID-19:

- Extreme obesity [BMI]>30
- A serious heart condition
- Chronic kidney disease
- Sickle Cell disease
- Immunocompromised resulting from a solid organ transplant
- Type 2 diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Cancer

☐ If one of the conditions above does not apply, I certify that I have viewed the CDC Guidance on high-risk individuals and that I have one of the conditions, identified below, that MIGHT put me at greater risk of severe illness from COVID-19:

- Asthma
- Cerebrovascular disease
- Hypertension or high-blood pressure
- A Neurologic condition (dementia)
- Liver disease
- Type 1 diabetes
- Pulmonary fibrosis
- Thalassemia
- Pregnancy
- Cystic fibrosis
- Immunocompromised from blood/marrow transplant, immune deficiencies, HIV, or medication that impacts the immune system

Sign here or digitally

Employee's Signature / Date

_____

Date Exception Needed in Place

CONTACT INFORMATION

_____

_____

Please direct questions to your Regional Disability Program Manager:

Anna Revere – DMEO Americas
Phone: 470-460-2026 ext 7026
Email: anna.revere@dodea.edu

Laura Tronge – DMEO Europe
314-545-1858 DSN
+49-(0)611-143-545-1858
Laura.Tronge@DODEA.EDU

Marco P. Bagnas –DMEO Pacific
DSN: (315) 644-5656
CIV: 011-81-98-953-5656
Marco.Bagnas@DODEA.EDU

Donna Walton - HQ
(571) 372-0965
Donna.walton@dodea.edu

Narrative Statement

Please explain specific concerns with personal work location and workspace.
Include any mitigation factors you believe could help your situation.

TO BE FILLED OUT BY THE MEDICAL PROVIDER: Mark as appropriate

Physician's Name _____

Telephone number: _____

Dates of Treatment: _____

Probable Duration of Condition:_____

☐ I certify that I have viewed the CDC guidance on high-risk individuals and that the Employee's condition meets one of the following:

- Extreme obesity [BMI]>30
- A serious heart condition
- Chronic kidney disease
- Sickle Cell disease
- Immunocompromised resulting from a solid organ transplant
- Type 2 diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Cancer

☐ If one of the conditions above does not apply, I certify that I have viewed the CDC guidance on high-risk individuals and that the Employee has a condition, identified below, that MIGHT put him/her at greater risk of severe illness from COVID-19:

- Asthma
- Cerebrovascular disease
- Hypertension or high-blood pressure
- A Neurologic condition (dementia)
- Liver disease
- Type 1 diabetes
- Pulmonary fibrosis
- Thalassemia
- Pregnancy
- Cystic fibrosis
- Immunocompromised from blood/marrow transplant, immune deficiencies, HIV, or medication that impacts the immune system

☐ I further certify that I have advised the Employee to self-quarantine or stay-at-home to mitigate their risk of harm from exposure to Covid-19. Meaning, I have instructed them to avoid public places except for medical appointments or the grocery, and to avoid socializing with anyone outside of their immediate household, despite improving local conditions.

Based on your knowledge of the Employee's condition, if conditions improved to the point of reopening the workplace, do you believe a combination of the following would sufficiently mitigate the risk of harm so that he/she could safely return to the workplace?

- Social distancing
- Mandatory use of face-coverings
- Increased cleaning and disinfectant of the workplace
- Reconfiguration of offices and classrooms to ensure safe distancing
- Plexiglas barriers where appropriate
- (other) _____ (Attach pages as needed)

◯ YES ◯ NO

Physician's Signature

_____

Contact Information:

_____

_____