THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

EQUAL OPPORTUNITY AND COMPLIANCE OFFICE

214 W. CAMERON AVE.
CAMPUS BOX 9160
CHAPEL HILL, NC 27599-9160
eoc.unc.edu

T 919-966-3576
F 919-445-1580

Accommodation Request Form

The University of North Carolina at Chapel Hill is committed to equal opportunity in all aspects of employment for qualified individuals with disabilities and other health conditions. The purpose of this form is to assist the University of North Carolina at Chapel Hill in determining whether, or to what extent, a reasonable accommodation is necessary for an employee with a disability or other health condition to perform one or more essential functions of his or her job safely and effectively.

The information you provide will be kept confidential consistent with State and Federal law. Please note that supervisors and managers may be informed regarding necessary accommodations; health and safety personnel may be informed if the condition might require emergency treatment; and government officials investigating compliance with applicable laws may be informed.

This form must be filed *in addition to* the Self-Identification of Disability form, if applicable. Self-Identification of Disability form is not required if a request is based only on pregnancy or weight.

Employee Information:

Name: ______________________

Department/Unit: ______________________ Position/Title: ______________________

Employment Status: ☐ EHRA ☐ SHRA ☐ Permanent ☐ Temporary

Phone # (Work): ______________________ PID #: ______________________

Phone # (Home/Cell): ______________________ Email Address: ______________________

Mailing Address (Please include CB# if office address): ______________________

____

____

Supervisor: ______________________ Phone #: ______________________

HR Rep: ______________________ Phone #: ______________________

Current Work Schedule/Shift: ______________________

Former/Existing Accommodations: ______________________

____

University Offices Contacted: ______________________

____

Date of Hire: ______________________

Disability Information:

1. Please indicate the nature of your disability or health condition:

- ☐ Chronic lung disease
- ☐ Chronic kidney disease
- ☐ Moderate to severe asthma
- ☐ Liver disease
- ☐ Serious heart condition, such as heart failure, coronary artery disease, or cardiomyopathies (Please specify condition)
- ☐ Thalassemia
- ☐ Immunocompromised due to conditions including, but not limited to, cancer treatment, bone marrow or organ transplants, immune deficiencies, poorly controlled HIV or AIDS, or prolonged use of corticosteroids or other immune-weakening medications (Please specify)
- ☐ Preexisting mental health conditions, including anxiety disorder, obsessive compulsive disorder, or post-traumatic stress disorder, that are exacerbated by disruptions due to COVID-19 (Please specify condition)
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Diabetes
- ☐ Cerebrovascular disease
- ☐ Cystic fibrosis
- ☐ Neurological conditions, such as dementia
- ☐ Sickle cell disease
- ☐ Pulmonary fibrosis
- ☐ High blood pressure or hypertension
- ☐ Pregnancy
- ☐ Obesity (BMI greater than 30)
- ☐ Other: The CDC may update the list of conditions that put individuals at a high risk. If your condition is listed by the CDC or your health care provider but not listed here, please describe your condition:

2. Please briefly describe any limitations or restrictions caused by your disability or health condition:

____
____
____
____

3. Please list any accommodation(s) you are requesting related to COVID-19 (i.e., continued telework, remote teaching, alternative or reduced schedule, alternative work-site, additional personal protective equipment, additional safety measures at work site):

____
____
____
____

4. Briefly describe your daily job duties:

____
____
____
____

5. Have you been provided a return-to-work date? If so, what date? ___________________________

Certification Page on Next Page

I hereby agree that the Equal Opportunity and Compliance Office is permitted to share relevant information from my physician or other health care provider(s) with the supervisor(s) in my immediate work unit and other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work related responsibilities.

I also agree that the EOC Office has my permission to contact my physician or other health care provider(s) for additional information to assist in developing reasonable accommodations for me.

By signing this document, I certify that I have been diagnosed by a physician or other health care provider with the condition identified. I also certify that, if requested by the EOC Office, I will provide medical documentation confirming this diagnosis. With respect to obesity, I certify that I have calculated my BMI to be over 30 or that I have been provided that information by a physician or other health care provider.

____

Name

_______________________________________ ____________________

Signature (Electronic Signature Accepted) Date

The University of North Carolina at Chapel Hill is an Equal Opportunity Employer that welcomes all, including protected veterans and individuals with disabilities.

Voluntary Self-Identification of Disability

OMB Control Number 1250-0005
Expires 05/31/2023

Name: ______________________________ Date: ______________________________
Employee ID: ______________________________
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability
☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability
☐ I Don't Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

<u>For Employer Use Only</u>

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:
Job Title: ________________ Date of Hire: ________________

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Health Care Provider – Medical Information Release Form

I, ____, voluntarily give the University of North Carolina at Chapel Hill, Equal Opportunity and Compliance Office permission to contact my physician(s) and/or healthcare provider(s) as listed below to obtain information related to my disability; any related limitations; and recommendations on necessary accommodations.

Name of Physician/Health Care Provider ____

Name of Hospital/Practice ____

Address ____

Telephone # ____

Name of Physician/Health Care Provider ____

Name of Hospital/Practice ____

Address ____

Telephone # ____

I have been given an opportunity to ask questions about this form and to have them answered to my satisfaction. I further understand that relevant information obtained may be shared with the supervisor(s) in my immediate work unit and other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work related responsibilities.

_________________________________ _________________________
Name Date of Birth

_________________________________ _________________________
Signature Today's Date

Last Revised 8/3/2018

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