State of Maryland
Reasonable Accommodation Request Form
CONFIDENTIAL

Employee or Applicant Name:	Job Title:
Daytime Phone #	Address:
Employee: ☐ Applicant: ☐	Request Date:

My disability/functional limitation is:

My disability/functional limitation prevents me from performing the following activities:

I am requesting accommodation because:

☐ I am applying for employment and the accommodation will allow me to participate in the application/selection process

☐ I am currently employed by the State and require an accommodation in my current position.

The accommodation I am requesting is: (Describe the type of accommodation, suggestions for work site or exam site modifications or specific job duties that may be restructured to facilitate your employment or participation, and the details of how or where the accommodation (if purchasable) may be obtained, including the cost if known)

This accommodation will allow me to perform the functions of my job or participate in the application/selection process as follows: (Describe how the accommodation will assist you)

☐ I UNDERSTAND THAT I MAY BE REQUIRED TO PROVIDE MEDICAL INFORMATION FROM MY HEALTH CARE PROVIDER AS PART OF THIS PROCESS.

Signature: _____

Print Name: _____

MEDICAL INQUIRY FORM – REASONABLE ACCOMMODATION REQUEST

***To be completed by Health Care Provider (Confidential)**

RETURN COMPLETED FORM TO: DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES OEEO ADA Coordinator, 6776 REISTERSTOWN ROAD, SUITE 306, Baltimore, MD 21215; Phone: 410-585-3005 Fax- 410-318-8905

NOTE: 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 an individual or family member of the individual, except as specifically allowed by this law. 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 an individual's 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 member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Name_____ **Job Title**_____

A. QUESTIONS TO HELP DETERMINE WHETHER AN EMPLOYEE HAS A DISABILITY

A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities. The following questions may help determine whether an employee has a disability:

Does the employee have a physical or mental impairment? ❑ Yes ❑ No
What is the impairment/diagnosis? _____

Is the impairment long-term or permanent? ❑ Yes ❑ No
If not permanent, how long will the impairment likely last? _____

Does the impairment affect a major life activity? ❑ Yes ❑ No
If yes, what major life activity(ies) is/are affected?

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

EMPLOYEE'S NAME _____

Is the employee substantially limited in one or more of these major life activities? ❑Yes ❑ No

B. QUESTIONS TO HELP DETERMINE WHETHER AN ACCOMMODATION IS NEEDED

Which of the major life activities selected are interfering with the employee's ability to perform the job functions?

_____

_____

What job function(s) is the employee having trouble performing because of the limitation(s)?

_____

_____

_____

_____

How does the employee's limitation(s) interfere with his/her ability to perform the job function(s)?

_____

_____

_____

_____

C. QUESTIONS TO HELP DETERMINE EFFECTIVE ACCOMMODATION OPTIONS

Please state any suggestions regarding possible accommodations to improve the employee's ability to perform his/her job.

_____

_____

_____

_____

_____

How would your suggestions improve the employee's ability to perform the job functions?

_____

_____

_____

_____

D. ADDITIONAL COMMENTS

_____

_____

Physician's Name (*Please Print*)

_____

Physician's Signature: _____ **Date:** _____/_____/_____

Phone: _____ **Fax:** _____

Physician's Checklist
for
Essential Duties of Parole and Probation Agent I, II and Senior

Name of Employee:_____

SS#:_____ Unit:_____

Individuals employed in Parole and Probation Agent positions must be able to perform the following essential duties.

IS THE INDIVIDUAL CAPABLE OF PERFORMING THE FOLLOWING DUTIES:

1.	Interview offenders and other persons for various agency purposes, e.g. determine risk assessment, determine progress on supervision	YES	NO
2.	Record offender case notes and reports in an electronic format on agency supplied personal computers to be accessed by others for official purposes.	YES	NO
3.	Visit offenders in their residences to assess home situations, and speak to offender and significant others regarding their adjustment to supervision.	YES	NO
4.	Complete agency forms, records and maintain files and records assigned to the agent in accordance with agency policy.	YES	NO
5.	Visually identify offenders in Court, at Parole Hearings or for law enforcement as the person under supervision	YES	NO
6.	Attend hearings in various courts and correctional facilities throughout the State to testify regarding offenders under supervision	YES	NO
7.	Communicate orally, in writing and electronically with agency staff, offenders criminal justice system partners and members of general public	YES	NO
8.	Drive or ride in personal vehicles to see offenders in their homes, places of employment, correctional institutions, courts or other community locations	YES	NO
9.	Follow agency procedure for the collection of urine specimens from offenders to test for substance abuse	YES	NO
10.	Maintain concentration and focus on each task until completed.	YES	NO

Physician's Comments:_____

_____

_____

_____

Name of Physician:_____ Date: _____

Address: _____

Telephone #: _____

Physician's Name Printed:_____

Revised October 2010