Instructions for USG Reasonable Accommodation Request Form/USG COVID-19 Alternative Work Arrangement

- Fill out applicable request form.
- Save the completed form to your computer.
- Send the form to the Office of Human Resources using one of the following methods:
    - Email the request form as an attachment in an encrypted email to humanresources@mga.edu (Preferred)
    - Print the completed request form and mail the request form to:

        Middle Georgia State University
        Office of Human Resources
        100 University Parkway
        Jones Building; Suite 230
        Macon, GA 31206

    - Fax the request to form to (478) 471-5383

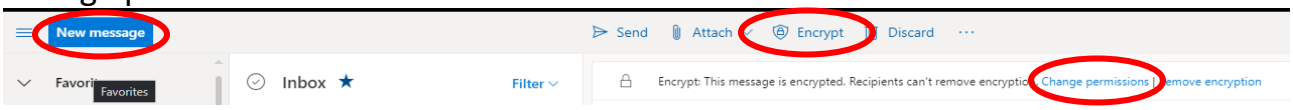
If you need assistance with this process, email humanresources@mga.edu or call (478) 471-2010.

Human Resources Leave Administrators will confirm with the employee and department when the request has been processed within OneUSG Connect.

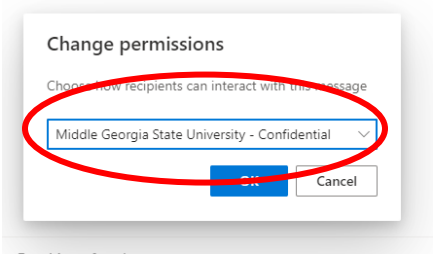
When sending Personally Identifiable Information (PII) through email, encrypting the email is the most secure way.

To send an encrypted email within Office 365 web outlook.

1. Login to Office 365 using your MGA credentials.
2. Go to Outlook.
3. New Message.
4. When the message box opens up, click on Encrypt.
5. Change permissions.

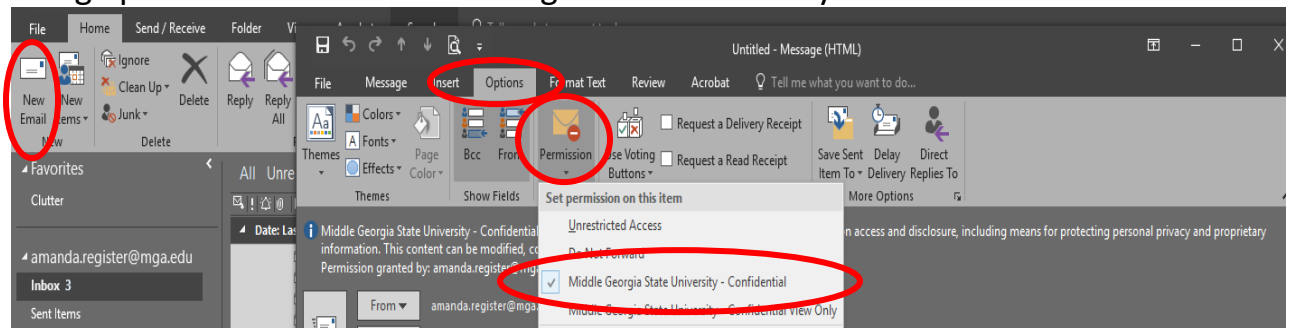


6. Change permissions to Middle Georgia State University - Confidential



To send an encrypted email within Outlook on your PC.

1. Click on New Email.
2. Go to Options within the new email window.
3. Click on Permissions.
4. Change permissions to Middle Georgia State University - Confidential



USG Reasonable Accommodations Request Form

The University System of Georgia (USG) provides reasonable accommodations for employees with ADA defined disabilities OR who may be covered by public health emergency guidance when necessary. A reasonable accommodation is an accommodation that enables the employee to perform the essential functions of their position, is medically necessary, and does not create an undue hardship to the institution. Employees who are requesting reasonable accommodation must complete and submit this request form along with supporting documentation to the Office of Human Resources at humanresources@mga.edu.

- A confidential interactive discussion with Human Resources is encouraged for employees who are seeking reasonable accommodations.
- If more information is needed, the Institution may require that you authorize your health care provider to confirm your disability and/or the need for the requested accommodation.
- It is your responsibility to ensure that your health care provider statement or other supporting documentation is returned to the Office of Human Resources.
- You are not required to disclose to your immediate supervisor the medical basis for a requested accommodation. Medical records are confidential and maintained in the Office of Human Resources only.

To request assistance with the process or form, please contact Vicky Smith, Executive Director of Human Resources at vicky.smith@mga.edu.

EMPLOYEE INFORMATION		
Employee Name:	Employee ID #:	
Employee Job Title:	Employee Department:	
Home Phone Number:	Cell Phone Number:	E-mail:
Supervisor Name:	Supervisor E-mail:	
ACCOMMODATION TIMEFRAME		
This is a *(choose one)*: ☐New request for accommodations ☐Request for an extension and/or alteration of existing accommodations* Physician confirmation may be required.		
Anticipated Begin Date of accommodations: _____ Expected end date of accommodations:_____		
NATURE OF THE QUALIFYING DISABILITY/PUBLIC HEALTH EMERGENCY (Select all that apply): What physical or mental impairment have you been diagnosed with by your physician(s) that require ADA accommodations? AND/OR What underlying medical condition or CDC defined status puts you at a greater risk for severe illness related to the public health emergency?		

USG Reasonable Accommodations Request Form

REQUESTED/SUGGESTED ACCOMMODATION: What Specific accommodation(s) are you requesting? Please select from the options below:

☐ Modification of job duties. Please describe:

Duration requested:_____ until _____

☐ Modification of work schedule (telework, flexible scheduling, reduction of hours, etc.). Please describe:

Duration requested:_____ until _____

☐ Modification of physical environment (i.e. alternative on-site work location). Please describe:

Duration requested:_____ until _____

☐ Leave of absence or intermittent leave use: Please describe and complete a copy of departmental leave form:

Duration requested:_____ until _____

☐ Assistive equipment. Please describe equipment you are requesting that the Institution provide:

☐ Facilities modification (e.g., doors widened, ramps installed). Please describe:

☐ Interpreter (Sign Language), reader, or real time captioning. Please describe:

☐ Classroom Reassignment. Please describe (include current and desired assignment):

☐ Other Accommodation. Please describe the accommodations you believe are needed to enable you to perform the essential functions:

USG Reasonable Accommodations Request Form

JOB DUTIES, ESSENTIAL FUNCTIONS, AND ACCESSIBILITY
Please provide a description of your current primary job duties, which of those duties you perceive could be performed with accommodations, and how. (Please attach additional pages if needed) Essential functions as outlined in the employee's official position description and/or from the employee's supervisor will also be reviewed. If more specific information is needed to respond to your request, a Job Analysis for your position may be prepared.
JUSTIFICATION NARRATIVE
Please describe how the accommodation(s) requested above will allow you to perform the essential functions of your position (attach separate sheet if necessary):

USG Reasonable Accommodations Request Form

HEALTH STATEMENT AND INFORMATION

☐ Health Care Provider Statement (Provider documentation of accommodation requirement or work arrangement needed)

☐ Other Supporting Documentation (Record of diagnosis or other supporting documents that meets public health emergency guidance)

PHYSICIAN CONTACT INFORMATION: The physician may receive communication from the institution's HR department requesting information on your impairment/disability and recommendations for accommodations.

Physician's Name: _____ Physician's Telephone #:_____ Physician's Fax #: _____	Physician's Email Address:_____ Physician's Address: _____

EMPLOYEE AUTHORIZATION

☐I authorize a representation of the Office of Human Resources to communicate directly with my health-care provider for confirmation of the impairment and clarification regarding the need for an accommodation.

Employee Signature: _____ Date: _____

EMPLOYEE CERTIFICATION

I certify that the above information is accurate and complete. I understand that I must contact the office of Human Resources regarding any changes or updates to this request as submitted.

Employee Signature: _____ Date: _____

HUMAN RESOURCES USE ONLY

Required documentation (if applicable) received from employee: No ☐ Yes ☐ Received on date:_____

Accommodations Decision: ☐ Approved ☐ Denied ☐ Modified as outlined below:

Name of Institutional Representative: _____

Signature of Institutional Representative: _____

June, 2020