

Questions to Clarify Accommodation Requested

What specific accommodation are you requesting?

If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore?

Yes No

If *yes*, please explain.

Is your accommodation request time sensitive?

Yes No

If *yes*, please explain

Questions to Document the Reason for Accommodation Request

What, if any, job functions are you having difficulty performing?

What, if any, employment benefits are you having difficulty accessing?

What limitation is interfering with your ability to perform your job or access an employment benefit?

Have you had any accommodations in the past for this same limitation?

Yes No

If yes, what were they and how effective were they?

If you are requesting a specific accommodation, how will that accommodation assist you?

Other

Please provide any additional information that might be useful in processing your accommodation request:

Employee Name

Signature

Date

Return this form to the Davis Behavioral Health, Inc. Human Resources Director at 934 South Main Street, Layton, Utah 84041

7. Please identify and describe any accommodations you are requesting and detail how these accommodations will enable you to perform those functions you are having difficulty with.

8. Please identify and describe any special equipment, methods, skills, or procedures that may enhance your abilities to perform one or more of the essential functions of your job.³

Employee Name

Signature

Date

³ The U.S. Equal Employment Opportunity Commission has indicated that an employer never has to remove an essential function of the job as an accommodation. Additionally, an employee with a disability must meet the same performance and production standards, whether quantitative or qualitative, as a non-disabled employee in the same job. Lowering or changing a production standard because an employee cannot meet it due to a disability is not considered a reasonable accommodation. Similarly, an employee who is chronically, frequently, and unpredictably absent may not be able to perform one or more essential functions of the job, or the employer may be able to demonstrate that any accommodation would impose an undue hardship, thus rendering the employee unqualified. Employers generally do not have to accommodate repeated instances of tardiness or absenteeism that occur with some frequency, over an extended period of time and often without advance notice. *The Americans with Disabilities Act: Applying Performance and Conduct Standards to Employees with Disabilities.*

MEDICAL/HEALTHCARE INFORMATION RELEASE FORM

Please submit a Medical/Healthcare Information Release Form for EACH health care provider you authorize to release information. This form will not be placed in your employment record file.

Patient Name _____ Date of Birth _____

Medical ID/Patient Number, or last 4 digits of Social Security Number: _____

Name and Title of Health Care Professional _____

Name of Facility: _____

Telephone Number _____ Fax Number _____

Address of Facility _____

Street

City _____ State _____ Zip _____

Please provide a brief description of disability/limitation for which you are requesting accommodation:

I do hereby authorize the DBH (the "Company") to communicate verbally and in writing, if necessary, with the appropriate health care or rehabilitation professionals with regard to the resolution of my request for an accommodation. I authorize the release of my complete health record relating to the disability/limitation listed above (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). My signature indicates that I am aware of the nature of the information being disclosed and with whom it will be shared. A complete photocopy of this authorization shall be accepted as if it were a signed original and is valid from the date of this release until the Company completes its evaluation of my request for accommodation of this condition.

I release the above named Physician/Medical Professional from any liability associated with the disclosure of confidential or privileged medical/healthcare information. I understand that the Company cannot evaluate properly my request for an accommodation unless I allow it to obtain information concerning my health information from my medical providers. I also understand that any information disclosed under this release could potentially be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that I may inspect or copy the health information disclosed pursuant to this release, and that I may obtain a copy of this release. The above-identified health care provider, except under limited circumstances, may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether this release is signed.

I understand that I may revoke this release in writing at any time by sending a written revocation of authorization to: Tim London, Human Resources Director, 934 South Main Street, Layton, Utah 84041 - timl@dbh.utah.org.

Employee Signature

Date



DAVIS

934 S Main Street Layton, UT 84041 801.773.7060

BEHAVIORAL HEALTH

www.dbhutah.org

Accounts Receivable Office

Brandon Hatch
Executive Director

Dear treating physician:

Dr. J. Noel Schenk
Medical Director

Your patient, _____ has asked his/her employer, Davis Behavioral Health, Inc. for a disability accommodation in the workplace.

Your patient has signed a release form allowing you to share medical information with Davis Behavioral Health, Inc. (enclosed) so that we can determine whether she is entitled to an accommodation and what accommodation might be appropriate.

Kristen Reisig
Clinical Director

Patient:
DOB:
Position:

Ryan Westergard
Chief Financial Officer

Please provide specific and detailed information about the patient's condition by completing the attached questionnaire. Fax the completed questionnaire to 801.336.1799 or e-mail it to me at the address below. Feel free to contact me by phone at 801.589.5918, or timl@dbhutah.org if you have any questions.

Tim London
Human Resources Director

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.

Shelly Tanner
Corporate Compliance

Thank you for your assistance.

Sincerely,

Tim London
Director, Human Resources

A. Questions to help determine whether an employee has a disability				
For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability:				
Does the employee have a physical or mental impairment?		Yes		No
If <i>yes</i> , what is the impairment?				
Is the impairment long-term or permanent		Yes		No
If <i>not</i> permanent, how long will the impairment likely last?				
Answer the following questions based on what limitations the employee has when his or her condition is in an active state and what limitations the employee would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.				
Does the impairment substantially limit a major life activity? <i>Note: Does not need to significantly or severely restrict to meet this standard.</i>		Yes		No
If <i>yes</i> , what major life activity(s) is(are) affected?				
<input type="checkbox"/> Caring For Self	<input type="checkbox"/> Walking	<input type="checkbox"/> Hearing	<input type="checkbox"/> Lifting	<input type="checkbox"/> Other: (describe)
<input type="checkbox"/> Interacting With Others	<input type="checkbox"/> Standing	<input type="checkbox"/> Seeing	<input type="checkbox"/> Sleeping	
<input type="checkbox"/> Performing Manual Tasks	<input type="checkbox"/> Reaching	<input type="checkbox"/> Speaking	<input type="checkbox"/> Concentrating	
<input type="checkbox"/> Breathing	<input type="checkbox"/> Thinking	<input type="checkbox"/> Learning	<input type="checkbox"/> Reproduction	
<input type="checkbox"/> Working	<input type="checkbox"/> Toileting	<input type="checkbox"/> Sitting		
Does the impairment substantially limit the operation of a major bodily function? <i>Note: Does not need to significantly or severely restrict to meet this standard.</i>		Yes		No

If yes, what bodily function is affected?			
<input type="checkbox"/> Immune <input type="checkbox"/> Normal Cell Growth <input type="checkbox"/> Digestive <input type="checkbox"/> Bowel <input type="checkbox"/> Bladder <input type="checkbox"/> Brain	<input type="checkbox"/> Genitourinary <input type="checkbox"/> Hemic <input type="checkbox"/> Special Sense Organs and Skin <input type="checkbox"/> Lymphatic <input type="checkbox"/> Neurological	<input type="checkbox"/> Respiratory <input type="checkbox"/> Circulatory <input type="checkbox"/> Endocrine <input type="checkbox"/> Reproductive <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Special Sense	<input type="checkbox"/> Cardiovascular <input type="checkbox"/> Other: (describe)

B. Questions to help determine whether an accommodation is needed

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with job performance?

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.

If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship. The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations to improve job performance?

Yes No

If so, what are they?

How would your suggestions improve the employee's job performance?

D. Comments.

Medical Professional's Signature

Date