Initial Request for a Reasonable Accommodation

A reasonable accommodation is any modification or adjustment to a job or change in the work environment that enables a qualified applicant with a disability to compete equally for a position or a qualified employee with a disability to perform the essential functions of the position.

The need for a reasonable accommodation is determined on a case-by-case basis, taking the following into consideration: the individual's specific disability and existing limitations relative to the performance of a job function, the essential duties of the job, the work environment, and the feasibility of the proposed accommodation.

You will be asked to:

- Complete a Reasonable Accommodations Packet (AD-1163), Confirmation of Request for Reasonable Accommodation; Medical Checklist; and, Release Form).
- Request your medical or healthcare provider to complete the Medical Checklist or provide medical documentation to address only the disability or medical condition related to the reasonable accommodation.
- Request your medical or healthcare provider to submit medical information to support the reasonable accommodations request which should describe the nature of your disability/medical condition, your limitations, and how the requested accommodation will assist you to perform the essential functions of your job.
- Return completed forms and medical documentation by email within *10 business days* (extensions may be granted) to RARequest@usda.gov.

The assigned Reasonable Accommodations Specialist will review the completed forms and documents to determine eligibility. If eligible, a letter will be issued to you with a copy to your supervisor.

The next step will be the interactive process with your supervisor to discuss the request.

If you have any questions, please contact one of the RA Specialists via email or phone at the following:

- Catherine Walker - (301) 851-2936
- Tiffany Lott - (301) 851-2930
- Ilycia Schwartz - (301) 851-2938

Please note the following:

- Your supervisor is the official with primary authority to grant or deny the accommodation.
- The accommodation provided should be effective, but it may not be the same as the accommodation requested.
- Medical documentation should not be submitted to your supervisor.
- All medical documentation received by the Reasonable Accommodations Staff is handled with sensitivity and is confidential. Medical information is kept in a secure database and will not be placed in an employee's Official Personnel File.
- Link to the Departmental Regulation for Reasonable Accommodations and Personal Assistance Services for Employees and Applicants with Disabilities https://www.ocio.usda.gov/document/departmental-regulation-4300-008

United States Department of Agriculture

Animal and Plant Health Inspection Service
HRD/WRWB/RA Program
4700 River Road, Unit 5, 3B-02
Riverdale, MD 20737
Phone: 301-851-2950
Fax: (833) 810-3174

CONFIRMATION OF REQUEST FOR REASONABLE ACCOMMODATION

Please give this request form to the Mission Area Designee for Reasonable Accommodations.

RA Request Number:

1. Applicant or Employee Name (Please Print):

Telephone Number:

Supervisor's Name and Telephone Number:

Employee's Agency:

Employee Occupational Series & Title:

Applicant or Employee E-mail address:

Date of Original Request:

2. What accommodation(s) do you think will help you?

3. If accommodation is time sensitive, please explain:

Signature **Date**

USDA, MRP, Reasonable Accommodations Program
4700 River Rd, Riverdale, MD 20737
Email: RARequest@usda.gov
Office: (301) 851-2950 Fax: (833) 810-3174

Medical Checklist

Employee/Applicant Seeking a Reasonable Accommodation

RA Request No: _____ **Patient Name: _____**

TO BE COMPLETED BY TREATING PHYSICIAN AND SHOULD ONLY INCLUDE CONDITIONS AND LIMITATIONS RELEVANT TO THE REQUESTED REASONABLE ACCOMMODATION. FORM MAY BE RETURNED BY FAX TO NUMBER LISTED ABOVE.

My patient has the following condition(s):

- ☐ ADD/ADHD
- ☐ Anxiety Disorder
- ☐ Arm Impairment
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disorder
- ☐ Back Impairment
- ☐ Bipolar Disorder
- ☐ Blindness
- ☐ Blood Diseases
- ☐ Cancer
- ☐ Cardiovascular/Heart Disease
- ☐ Carpal Tunnel Syndrome
- ☐ Cerebral Palsy
- ☐ Chemical Sensitivities
- ☐ Chronic Fatigue Syndrome
- ☐ Coronary Artery Disease
- ☐ Deafness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Impairment
- ☐ Dyslexia/Dysgraphia
- ☐ Endocrine Impairment
- ☐ Epilepsy or Seizure Disorder
- ☐ Fibromyalgia
- ☐ Gastrointestinal Disorders
- ☐ Genitourinary Impairment
- ☐ Head Injury
- ☐ Hearing Impairment
- ☐ Hemic Impairment
- ☐ High Blood Pressure
- ☐ History of Alcoholism
- ☐ HIV /AIDS
- ☐ Intellectual Disabilities
- ☐ Kidney Dysfunction
- ☐ Learning Disabilities
- ☐ Leg/Knee Impairment
- ☐ Lymphatic Impairment
- ☐ Mental or Emotional Illness
- ☐ Migraine Headaches
- ☐ Missing Extremities
- ☐ MS/MD
- ☐ Musculoskeletal Impairment
- ☐ Neck Impairment
- ☐ Neurological Impairment
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Post-Traumatic Stress Disorder
- ☐ Pregnancy (High Risk)
- ☐ Pulmonary Impairment
- ☐ Reproductive Impairment
- ☐ Respiratory Impairment
- ☐ Schizophrenia
- ☐ Seasonal Affective Disorder
- ☐ Sensory Processing Disorder
- ☐ Skin Impairment
- ☐ Special Sense Organ Impairment
- ☐ Sleep Disorder
- ☐ Speech Impairment
- ☐ Spinal Abnormalities
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ Visual Impairment
- ☐ Other: _____

My patient is or may be limited in the following Major Life Activities:

- ☐ Bending
- ☐ Breathing
- ☐ Caring for Oneself
- ☐ Communicating
- ☐ Commuting
- ☐ Concentrating
- ☐ Driving
- ☐ Eating
- ☐ Hearing
- ☐ Interacting with Others
- ☐ Learning
- ☐ Lifting (no lifting over _____ lbs.
- ☐ Performing Manual Tasks
- ☐ Pulling
- ☐ Pushing
- ☐ Reaching
- ☐ Reading
- ☐ Seeing
- ☐ Sitting
- ☐ Sleeping
- ☐ Speaking
- ☐ Standing
- ☐ Thinking
- ☐ Traveling
- ☐ Walking
- ☐ Working
- ☐ Other _____

Regarding Interactions with Others: Patient's condition poses a risk of harm:
____ to self? Explain:_____
____ to others? Explain:_____

Regarding Driving or commuting: Any restrictions on driving? __ Y __ N If YES, explain:_____
Any restrictions on commuting? __ Y __ N If YES, explain:_____

Expected Duration of Condition: _____ 0-6 months ____ 6 months -1 year ____ Over 1 year ____ Permanent

Are there modifications to the job duties or work environment that would help this patient to perform his/her job? If so, please describe (may attach).

_____

_____

Health Professional Information:

Name:_____
Signature: _____
Telephone Number: _____
Fax Number: _____

Practice Name: _____
Address: _____
_____
Date: _____

United States Department of Agriculture

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MEDICAL RELEASE FORM

RA Request Number:

This Authorization form is intended to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508

I, give permission for my medical provider(s):

Name of my Doctor:

Address of Doctor:

Doctor's Phone Number :

to speak with and/or provide specific information regarding my current medical condition(s) related to my request for a reasonable accommodation(s) to the following individuals: APHIS Medical Officer; USDA Medical Officer; MRP Mission Area Designee for Reasonable Accommodations; and, those individuals who are involved in the reasonable accommodation process and/or other related processes.

This information is needed to determine whether I have a disability as defined by the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act, as amended; what functional limitation(s) I have in performing the essential functions of my position; and, if there is a reasonable accommodation(s) related to my disability that will allow me to perform the essential function of my job.

A photocopy of this form shall be deemed authorization of the release of the requested information.

Employee's Signature Date

(Print Employee's Name)

Please sign this form and submit it via scan/email to your servicing Reasonable Accommodations Specialist or to the APHIS RA Mailbox at RARequest@usda.gov. **The form may also be sent via fax to (833) 810-3174.**