



The sample forms provided as part of this presentation are intended merely for informational purposes. No representation is made as to the enforceability of these forms in any jurisdiction, and the materials should not be relied upon or construed as legal advice, or as a substitute for obtaining legal advice from an attorney licensed in the applicable jurisdiction(s).

**REASONABLE ACCOMMODATION CHECKLIST**<sup>1</sup>

**I. Initiating the Process**

**A. Triggers for a reasonable accommodation analysis**

1. The request can be verbal, written or both.
2. The process can be triggered without any specific request if the need for an accommodation is obvious, *e.g.*, an employee is in a wheelchair
3. The request does not have to use the words “ADA,” “disability” or “reasonable accommodation.”
4. When an employee links an alleged medical condition to
  - a. a complaint about a working condition or
  - b. a request or demand for a job modification or special treatment
5. When an employee expresses a desire for assistance based on a disability.

How did the issue of a reasonable accommodation arise?

---

---

---

---

Describe and document the statements of the employee, supervisor, or medical provider that raised the issue of whether the employer should consider an accommodation under the ADA or state law.

---

---

---

---

---

<sup>1</sup> This checklist was prepared based on federal law; however, state law may provide different or additional requirements.

**II. Determining Whether the Employee Has a Disability**

**A. Definition of Disability (for cases arising on or after January 1, 2009):**

1. A physical or mental impairment that substantially limits a major life activity.

**B. Definition of a Disabled Individual**

1. One who has a physical or mental impairment that substantially limits one or more of the individual's major life activities;
2. One who has a record of such an impairment; or
3. One who is regarded as having such a disability.

Does employee have a current disability?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Does she/he have an impairment?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, what is the impairment? (Request formal diagnosis, where relevant)

---

---

---

---

What is the employee's healthcare provider's opinion as to causation and, in particular, as to whether the employee's job or work environment may have caused or contributed to the employee's impairment?

---

---

---

---

What are the symptoms of the employee's impairment? (Describe the nature and severity of the impairment.)

---

---

---

- 
- Discuss evidence of impairment.

*Discuss with employee and if unable to obtain sufficient information to make a determination, contact employee's medical provider (obtain medical authorization form).*

*You may request only the documentation needed to establish that a person has a disability and that the disability necessitates a reasonable accommodation. You may only ask disability-related questions and send employee for a medical exam if inquiries are job-related and consistent with business necessity.*

- Is a major life activity affected by the impairment?

\_\_\_\_\_ Yes                  \_\_\_\_\_ No

If yes, what is the alleged major life activity? (Check all that apply)

- |                 |                               |                          |
|-----------------|-------------------------------|--------------------------|
| _____ Walking   | _____ Reaching                | _____ Working***         |
| _____ Speaking  | _____ Bending                 | _____ Reproduction       |
| _____ Breathing | _____ Lifting                 | _____ Sexual Functions   |
| _____ Hearing   | _____ Interacting with Others | _____ Eating             |
| _____ Seeing    | _____ Communicating           | _____ Controlling Bowels |
| _____ Thinking  | _____ Learning                | _____ Reading            |
| _____ Sitting   | _____ Concentrating           | _____ Running            |
| _____ Standing  | _____ Caring for Oneself      | _____ Sleeping           |
- \_\_\_\_\_ Major Bodily Functions (e.g., bladder and brain functions)
- \_\_\_\_\_ Performing Manual Tasks (including household chores, bathing, brushing teeth)
- \_\_\_\_\_ Other (Describe) \_\_\_\_\_

- \*\*\*If the major life activity is "working," identify the class of jobs or broad range of jobs that the individual cannot perform because of the impairment. Also, identify the jobs that are still available to the individual.

---

---

Does the impairment substantially limit<sup>2</sup> the major life activity?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

*Discuss what the employee cannot do, as well as what the employee is able to do. Compare the employee's abilities/limitations to those of the average person. Note that even if the employee takes medications, uses prosthetic devices or has learned behavioral modifications to compensate the impairment, the determination of whether the impairment substantially limited the major life activity must be based upon what the employee's condition would be like **without** such medication, mitigating measures, or behavioral modifications (except for ordinary eyeglasses or contact lenses). Similarly, if a condition is episodic or in remission, make the determination based upon the symptoms of the impairment when active, not when absent.*

How long is the condition expected to last?<sup>3</sup>

---

---

---

---

What is the proposed course of treatment?

---

---

---

---

What is the employee's healthcare provider's opinion as to whether the employee's condition precludes him/her from performing any of the essential functions of his/her job and, if so, the physician's opinion as to the nature and duration of such limitation(s)?

---

<sup>2</sup> The statute and regulations state that "substantially limited" is to be construed broadly in favor of expansive coverage. An impairment does not need to prevent or severely or significantly restrict a major life activity to be considered "substantially limiting."

<sup>3</sup> Note, when determining whether an individual has an (1) actual disability or a (2) record of a disability, the duration of the condition is inconclusive. However, in defense to a charge of discrimination by an individual claiming coverage under the "regarded as" prong of the definition of disability, an impairment which is or would be "transitory" (i.e., lasting or expected to last six months or less) and minor" is not a disability.

---

---

---

---

- If the employee did not suggest a particular accommodation when he/she initially put the employer on notice of his/her need for an accommodation, obtain the employee's and/or his/her healthcare provider's input as to potential accommodation(s) that would permit the employee to perform the essential functions of his/her job. If it would be helpful in formulating an opinion as to a potential accommodation, the employer should offer to allow the healthcare provider to observe the employee's job being performed.

---

---

---

---

**C. Determining Whether Employee is Qualified**

**1. Definition of Qualified**

- a. The employee with a disability has the background required for the job, and he/she can perform the essential functions of the job (either without any accommodations, or with a reasonable accommodation).

**2. Definition of Essential Functions**

- a. Those aspects of a job that are considered to be central to or fundamental to the job, not those components of a job that are marginal or incidental.

- What are the "functions" of the job (as distinguished from the ways of performing those functions)?

---

---

---

---

- What are the "essential" functions of the job?

---

---

---

---

- What evidence/documentation supports this determination that it is an essential function of the employee's job?

- Written job description
- Employer's judgment
- Amount of time spent performing function
- Consequences of not performing function
- Special skills needed to perform job
- Terms of collective bargaining agreement
- Actual experience of current employees in same or similar position
- Actual experience of past employees in same or similar position
- Nature of work operation
- Organizational structure
- Other \_\_\_\_\_

- What are the "marginal" functions of the job?

---

---

---

---

- What evidence/documentation supports this determination that they are marginal functions of the job?

---

---

---

---

- Can the employee perform the essential functions of the position, either without a reasonable accommodation or with a reasonable accommodation (if needed)?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If no, discuss: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Will the employee be able to perform the essential functions of the position, either without a reasonable accommodation or with a reasonable accommodation, if a leave of absence is provided?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, discuss how leave of absence will allow employee to return to his or her duties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D. Determining Whether Employee Needs Reasonable Accommodation**

1. Definition of and Consideration of Reasonable Accommodation
  - a. Any change to the application process, work process or the way work is ordinarily accomplished that enables an otherwise qualified individual with a disability to perform the essential functions of the job, or to otherwise enjoy the benefits of equal employment.
  - b. The employer is not required to provide the accommodation preferred by the employee.
  - c. In the event that there are two equally effective accommodations, the employer may choose the one that is most cost-effective or easiest to supply.
  - d. The employer is not obligated to provide the best possible accommodation, so long as the accommodation it chooses allows the employee to perform the essential functions of the job.
  - e. If the accommodation, once implemented, does not resolve the situation, the employer's responsibility to engage in the interactive process continues.

- Has the reasonable accommodation process been triggered because the employee has requested a job modification because of a medical condition that could be a disability?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If no, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Has the reasonable accommodation process been triggered because the employer knows the employee has a disability and has reason to know that the employee needs a reasonable accommodation?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If no, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the reasonable accommodation process has been triggered, send the Model “Reasonable Accommodation Interactive Process Letter and Questionnaire (employee request for accommodation)” interactive process letter to employee, accompanied by a completed “List of Essential Physical / Cognitive Job Functions.”

- Did the employee and his/her healthcare provider provide complete information in response to your request?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If no, send the Model Reasonable Accommodation Follow-up Letter (insufficient info), or the Model Reasonable Accommodation Follow-up Letter (no info provided).

If yes, does the employee’s healthcare provider’s believe the employee’s condition precludes him/her from performing any of the essential functions of his/her job?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

- If yes, what is the healthcare provider's opinion as to the nature and duration of such limitation(s)?

---

---

---

---

- In which aspect of employment is reasonable accommodation needed?
- \_\_\_\_\_ Application process
  - \_\_\_\_\_ Performance of job (including leave)
  - \_\_\_\_\_ Benefits and privileges of employment
- What accommodation (if anything specific) was requested?
- \_\_\_\_\_ Acquisition or modification of equipment, machinery or devices
  - \_\_\_\_\_ Making facility readily accessible to and usable by the employee
  - \_\_\_\_\_ Readers
  - \_\_\_\_\_ Interpreters
  - \_\_\_\_\_ Providing helper or job coach
  - \_\_\_\_\_ Modification of policy (including Leave Policy)
  - \_\_\_\_\_ Accessibility
  - \_\_\_\_\_ Job restructuring, including reallocation of marginal functions)
  - \_\_\_\_\_ Modification to work schedule, including part-time schedule
  - \_\_\_\_\_ Acquisition or modification of equipment or devices
  - \_\_\_\_\_ Telecommuting
  - \_\_\_\_\_ Adjustment/modification of examinations, training materials or policies
  - \_\_\_\_\_ Shift change
  - \_\_\_\_\_ Reassignment or transfer to vacant position
  - \_\_\_\_\_ Leave of absence
  - \_\_\_\_\_ Other \_\_\_\_\_
- Describe the accommodation requested:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Is the reasonable accommodation needed because of the disability?
- \_\_\_\_\_ Yes          \_\_\_\_\_ No
- If no, discuss: \_\_\_\_\_

---

---

---

- How will the accommodation allow the employee to perform the essential functions of the position?

---

---

---

- Did you engage in “interactive process” to identify an effective accommodation?

\_\_\_\_\_ Yes (Describe with specificity and provide documentation)

\_\_\_\_\_ No (Discuss. **This is a requirement. Must discuss with HR and/or Legal**)

---

---

---

- Did you discuss accommodation with the employee?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

See Guidelines for Reasonable Accommodation Interview with Employee (Ellen Toth, contact information below, can provide).

You must document the discussions (include attachments, if necessary).

---

---

---

- Have you or the Company’s medical representative discussed the restrictions and possible accommodations with the employee’s medical provider or requested information in writing from the employee’s medical provider?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, document discussions (include attachments, if necessary).

---

---

---

---

Has accommodation been provided?

\_\_\_\_\_ Yes          \_\_\_\_\_ No

Describe the accommodation.

---

---

---

---

---

---

Did the employee accept the accommodation?

\_\_\_\_\_ Yes          \_\_\_\_\_ No

If the employee did not accept the accommodation, why not?

---

---

---

---

If the employee accepted the accommodation, is the accommodation effective (i.e., does it work?)

\_\_\_\_\_ Yes          \_\_\_\_\_ No

**E. Determining Whether Employee Poses a Direct Threat**

**2. Definition of Direct Threat**

- a. The employee with a disability poses a *significant risk of substantial harm* to him/herself or others that is objective, specific, current and non-speculative, and there is not a

reasonable accommodation that would lower the risk or harm below that level.

b. This is a high burden and should be discussed with HR and/or Legal before any such determination is made.

Is the employee being screened out for a position or promotion, reassigned, demoted, disciplined, placed on leave, or terminated for safety-related reasons?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes:

Is the specific risk identified?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Describe the risk (*e.g.*, contagion, injury, etc.)

---

---

---

Is the risk significant (*i.e.*, highly probable)?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

What is the duration of the risk?

---

---

---

---

Describe the harm:

---

---

---

---

---

---

Is the harm substantial (*i.e.*, serious)?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Is the harm imminent?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Can the risk of the harm be reduced by providing a reasonable accommodation?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Did you engage in the “interactive process” to identify an effective accommodation?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Did you discuss accommodation with the employee?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, document discussions (include attachments, if necessary).

---

---

---

---

Have you or the Company’s medical representative discussed the possible accommodations with the employee’s medical provider *{after obtaining release}* or requested information in writing from the employee’s medical provider?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, document discussions/information (include attachments, if necessary)

---

---

---

---

If no, is this because, despite the employer's best efforts, (1) the employee or the employee's medical representative did not fully respond to the employer's request for information, or (2) failed to respond at all to the requested information?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, document all efforts to obtain the requested information (include attachments, if necessary), and send the Model Reasonable Accommodation Follow-up Letter (insufficient info), or the Model Reasonable Accommodation Follow-up Letter (no info provided)

---

---

---

---

- Did you request assistance in determining accommodation from any third party or outside source?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, document discussions (include attachments, if necessary).

---

---

---

---

If no, is this because, despite the employer's best efforts, (1) the employee or the employee's medical representative did not fully respond to the employer's request for information, or (2) failed to respond at all to the requested information?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, document all efforts to obtain the requested information (include attachments, if necessary), and send the Model Reasonable Accommodation Follow-up Letter (insufficient info), or the Model Reasonable Accommodation Follow-up Letter (no info provided)

---

---

---

---

Has an accommodation been provided?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, is the accommodation effective (*i.e.*, does it work?)

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

**F. Will the Accommodation Create an Undue Hardship?**

**1. Definition of an Undue Hardship**

a. Significantly difficult or expensive when considered in light of the overall operational and/or financial resources of the employer.

b. This is a high burden, which should be substantiated with objective evidence and discussed with HR and/or Legal before making any such determination.

Do you believe that providing reasonable accommodation would impose an undue hardship?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes:

What objective evidence exists to support undue hardship?

---

---

---

---

Specify the nature and net cost of accommodation. Be sure to consider and discuss the availability of tax credits and deductions, and/or outside funding

---

---

---

---

- Overall financial resources of facility/facilities, number of employees at facility, and effect on expenses and resources

---

---

---

---

- Overall financial resources of covered entity, overall size of business of covered entity with respect to the number of employees and the number, type and location of facility/facilities

---

---

---

---

- Type of operation(s) of covered entity, including composition, structure, and functions of the workforce of covered entity, and geographical separateness and administrative or fiscal relationship of facility/facilities in question to the covered entity

---

---

---

---

- Impact of the accommodation on the operation of the facility, including impact on other employees' ability to perform duties and facility's ability to conduct business

---

---

---

---

- Terms of a collective bargaining agreement (*discuss how the accommodation would affect the rights of other employees, and whether you tried to negotiate a change to CBA*)

---

---

---

---

- Describe and document evidence supporting basis for undue hardship:

---

---

---

---

If you have any questions about this form, please contact Ogletree Deakins shareholder Ellen Toth at (216) 274-6907 or [ellen.toth@ogletreedeakins.com](mailto:ellen.toth@ogletreedeakins.com).

© Ogletree, Deakins, Nash, Smoak & Stewart, P.C.