Appendix B
Wisconsin National Guard Reasonable Accommodation & Personal Assistance Forms

1. Request for Reasonable Accommodation or Personal Assistance Services
2. Recommendations and Reviews of Reasonable Accommodation or Personal Assistance Services
3. Determination of Accommodation Request
4. Information Reporting for Reasonable Accommodation
5. Medical Inquiry for Reasonable Accommodation

WISCONSIN NATIONAL GUARD

REQUEST FOR REASONABLE ACCOMMODATION OR PERSONAL ASSISTANCE SERVICES

To Employee: The intent of this form is to facilitate the interactive process in a timely manner. The interactive process is designed to identify an accommodation that is reasonable and effective and does not impose an undue hardship on the employee and employer. Employees are not required to complete this form to request an accommodation, if applicable, supervisors can initiate a request for the employee. Return completed forms to the direct supervisor or the Disability Program Manager.

For assistance or questions: Contact Disability Program Manager at 608-242-3701 or by email at ng.wi.wiarng.mbx.eo-disability-program@army.mil.

Any information collected in this document, as well as during the interactive process, will be kept confidential in accordance with the Rehabilitation Act, applicable laws and regulations. Collected information will be kept in files separated from personnel files.

Requesting an accommodation and participating in the interactive process is a protected activity, and WING employees will not be retaliated against for engaging in the process. Any employee who feels they have experienced retaliation for participating in this process should contact the WING State Equal Employment Management (SEEM) Office at 608-242-3702 within 45 days of the alleged retaliation.

Employee Name: _____

Email: _____

Contact Phone Number: _____

Supervisor Name: _____

Email: _____

Contact Phone Number: _____

Privacy Act Statement

The Rehabilitation Act of 1973, 29 U.S.C. section 791, and Executive Order 13164 authorize collection of this information. The primary use of this information is to consider, decide, and implement requests for reasonable accommodation (RA).

Additional disclosures of the information may be: To medical personnel to meet a bona fide medical emergency; to another Federal agency, a court, or a party in litigation before a court or in an administrative proceeding being conducted by a Federal agency when the Government is a party to the judicial or administrative proceeding; to a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of the individual; and to an authorized appeal grievance examiner, formal complaints examiner, administrative judge, equal employment opportunity investigator, arbitrator or other duly authorized official engaged in investigation or settlement of a grievance, complaint or appeal filed by an employee.

REQUEST FOR REASONABLE ACCOMMODATION OR PERSONAL ASSISTANCE SERVICES

Log Number:

FOR COMPLETION BY EMPLOYEE/APPLICANT. Please fully answer each item on this page of the form, then provide the form to your supervisor or selecting official to complete the supervisor portion. You may also email this form to the Disability Program Manager at ng.wi.wiarng.mbx.eo-disability-program@army.mil. The information you submit will be treated as confidential to the extent permitted by law. Please note **this request cannot be processed unless the employee and supervisor portions are completed.**

I am a person with a disability who is requesting a Reasonable Accommodation and/or Personal Assistance Services under the Rehabilitation Act of 1973, as amended. Please Select Below.

☐ Reasonable Accommodation ☐ Personal Assistance Service

1. Name:	2. Pay Plan – Series – Grade:	3. Job Title:	4. Directorate/Brigade/Wing:

5. Please annotate your WING employment status below:

☐ Title 5 Employee ☐ Title 32 Employee ☐ Title 5/32 Applicant

6. Do you have a medical condition that impairs or limits your ability to perform assigned job duties?

☐ YES ☐ NO

7. What activity or activities is/are affected by the impairment**?**

☐ Bending	☐ Interacting with Others	☐ Reading	☐ Standing
☐ Breathing	☐ Learning	☐ Seeing	☐ Thinking
☐ Eating	☐ Lifting	☐ Sitting	☐ Walking
☐ Caring for Self	☐ Performing Manual Tasks	☐ Sleeping	☐ Other (describe):
☐ Concentrating	☐ Reaching	☐ Speaking	

8. What is the expected duration of your impairment/limitation?

9. If you are requesting a specific accommodation(s), how will that accommodation(s) assist you to perform your job?

10. Has a health care professional recommended a specific accommodation? Please provide the documentation:

11. Have you had any accommodation in the past for this same limitation? If yes, please provide the documentation from previous accomodation.

12. Is this request time sensitive? If yes, please explain.

13. Requester Signature:	14. Date:

Warning: Information contained in this document is protected by the Privacy Act (5USC 552a)

RECOMMENDATIONS AND REVIEWS OF REASONABLE ACCOMMODATION OR PERSONAL ASSISTANCE SERVICES

SECTION I
RECOMMENDATIONS

SUPERVISOR

1. Supervisor's Name:	2. Phone Number:
3. Recommend Approval/Approval With Modification/Denial and Justification (Review the RA in conjunction with the Position Description (PD) and include a copy of the PD):	
4. Supervisor Signature:	5. Date:

SERVICE MEDICAL REPRESENTATIVE

6. SMR Name:	7. Phone Number:
8. Does the PD support approval of the Reasonable Accommodation? Please explain:	
9. SMR Signature:	10. Date:

DISABILITY PROGRAM MANAGER

11. DPM Name:	12. Phone Number:
13. I have reviewed the documentation provided and still need the following documents:	14. Signature:

SECTION II
REVIEWS

15. Director/Wing Commander's Name:	16. Phone Number:
17. I have reviewed the proposed reasonable accommodation and have the following comments:	18. Signature
19. Labor Relations Specialist's Name:	20. Phone Number:
21. I have reviewed the proposed reasonable accommodation and have the following comments:	22. Signature:
23. State Judge Advocate's Name:	24. Phone Number:
25. I have reviewed the proposed reasonable accommodation and have the following comments:	26. Signature:

DETERMINATION OF REASONABLE ACCOMMODATION/PERSONAL ASSISTANCE SERVICES

SECTION III
APPROVAL/DENIAL

REASONABLE ACCOMMODATION DECISION AUTHORITY

1. Recommended Reasonable Accommodation:

2. Name of HRO Decision Authority:	3. Contact Phone Number:
4. Approval/Approval With Modifications/Denial: ☐ Approved ☐ Approved with Modifications ☐ Denied	5. Date:

6. Justification for Approval with Modifications or Denial:

7. If Denied, check reasons for denial (check all applicable boxes)

- ☐ The claimed disability is not covered by the Rehabilitation Act
- ☐ The individual did not provide proper documentation of a disability that substantially limits a major life activity.
- ☐ The requested accommodation for a disability will not enable the individual to perform the essential functions of the position (i.e. the requested accommodation is ineffective).
- ☐ The individual's disability/limitations do not prevent the person from performing the essential functions of the position.
- ☐ The accommodation would require removal of an essential function of the job.

The accommodation being requested will:

- ☐ Create an undue administrative burden.
- ☐ Create an undue impact on operations.
- ☐ Fundamentally alter the nature or operation of the facility.
- ☐ Require lowering of a current performance standard.

- ☐ An effective accommodation that would not impose an undue hardship was offered but rejected by the individual.

8. HRO Signature:

Notification of Appeal and Statutory Rights

Individuals who disagree with the resolution of their accommodation request may ask HRO to reconsider the decision within 7 calendar days of the receiving the resolution. A request for reconsideration will not extend the time limits for initiating administrative, statutory, or collective bargaining claims. Submit appeal requests to:

Director, Human Resources Office
Joint Forces Headquarters
2400 Wright Street
Madison, WI 53704

Individuals have the right to file an informal complaint if they believe the denial of the RA or PAS request was discrimination or harassment based on their disability. A complaint must be filed with the Equal Opportunity Director/State Equal Employment Manager, within 45 calendar days after the date of the denial, or when the applicant or employee became aware of the denial. If an individual is dissatisfied with the resolution and wishes to pursue administrative, statutory, or collective bargaining rights, they must take the following steps:

1. For a collective bargaining claim, file a written grievance in accordance with the provisions of the Collective Bargaining Agreement.
2. For adverse actions over which the Merit System Protection Board has jurisdiction, initiate an appeal to the MSPB within 30 calendar days of an appealable adverse action as defined in 5 C.F.R. subsection 1201.3.

DETERMINATION OF REASONABLE ACCOMMODATION/PERSONAL ASSISTANCE SERVICES

Notification of Rights and Responsibilities of Requester

1. It is the responsibility of the individual who receives an accommodation to inform their supervisor or the Disability Program Manager (DPM) if their approved accommodation is no longer effective (e.g. software or hardware provided no longer works after a system update, or a person with low-vision whose vision has worsened and the larger monitors they were provided are no longer adequate) or if they need additional accommodations. This can occur from the disability worsening or the individual being assigned to a new position which requires an additional or different accommodation. The DPM can be contacted by email at ng.wi.wiarng.mbx.eo-disability-program@army.mil
2. If an accommodation request is denied, the requester may request a reconsideration within 7 calendar days from notification of the accommodation request decision. If the reconsideration is denied, the requester may request an appeal with 7 calendar days from notification of the reconsideration decision. Additionally, the requester may make another request at a later date if circumstances change and an accommodation is needed due to limitations.
3. Any equipment provided as part of an accommodation must be returned when an employee leaves the employment of the Wisconsin National Guard.

SECTION IV
DECISION NOTIFICATION

SUPERVISOR

9. Supervisor Signature:	10. Date:

REQUESTER

11. Requester Signature:	12. Election of Decision: ☐ Accept Decision ☐ Request Reconsideration
13. Date of Election:	

REQUEST FOR RECONSIDERATION

14. Reconsideration Justification by Requester:

15. Requester Signature:	16. Date:

SECTION V
RECONSIDERATION DECISION BY HUMAN RESOURCES OFFICER

17. Reconsideration Decision by HRO:

18 HRO Signature:	19. Date:

SECTION VI
RECONSIDERATION NOTIFICATION

SUPERVISOR

20. Supervisor Signature:	21. Date:

REQUESTER ELECTION

22. Requester Signature:	23. Election of Decision: ☐ Accept Reconsideration ☐ Request Appeal
24. Date of Election:	

DETERMINATION OF REASONABLE ACCOMMODATION/PERSONAL ASSISTANCE SERVICES

REQUEST FOR APPEAL

25. Appeal Justification by Requester:

26. Requester Signature:	27. Date:

SECTION VII
APPEAL DECISION BY CHIEF OF STAFF - JOINT STAFF

28. Appeal Decision by JCS:

29. JCS Signature:	30. Date:

SECTION VIII
APPEAL NOTIFICATION

SUPERVISOR

31. Supervisor Signature:	32. Date:

REQUESTER

33. Requester Signature:	34. Date:

Individuals have the right to file an informal complaint if they believe the denial of the RA or PAS request was discrimination or harassment based on their disability. A complaint must be filed with the Equal Opportunity Director/State Equal Employment Manager, within 45 calendar days after the date of the denial, or when the applicant or employee became aware of the denial. If an individual is dissatisfied with the resolution and wishes to pursue administrative, statutory, or collective bargaining rights, they must take the following steps:

1. For a collective bargaining claim, file a written grievance in accordance with the provisions of the Collective Bargaining Agreement.
2. For adverse actions over which the Merit System Protection Board has jurisdiction, initiate an appeal to the MSPB within 30 calendar days of an appealable adverse action as defined in 5 C.F.R. subsection 1201.3.

If an accommodation request is denied, the requester may make another request at a later date if their circumstances change and an accommodation is needed due to changed or increased limitations. The DPM can be contacted by email at ng.wi.wiarng.mbx.eo-disability-program@army.mil

INFORMATION REPORTING FOR REASONABLE ACCOMMODATION

This form must be completed by the supervisor, or the person who approved the accommodation, and provided to the Disability Program Manager for tracking and continuity of the workplace accommodation. Questions should be directed to the Disability Program Manager at 608-242-3701 or ng.wi.wiarng.mbx.eo-disability-program@mail.mil

1. Date Request Made	2. Employee Name

3. Pay Plan – Series – Grade	4. Job Title	5. Directorate/Brigade/Wing

6. Employee Status

☐ Title 32 Employee ☐ AGR ☐ Title 5/32 Applicant

7. What kind of workplace accommodation is being provided?

8. What is the expected duration of the employee's limitation(s)**?**

9. Was the Service Medical Representative (SMR) Consulted? If so, what was their recommendation?

10. Date Accommodation Approved	11. Date Accommodation Expires ☐ NA	12. Date Recommended for Denial

13. Name of Supervisor:	14. Job title of Supervisor	15. Supervisor Signature

16. Justification of Recommended Denial

17. Labor Relations Specialist Review and Recommendation:	18. Labor Relations Signature:

19. SJA Review and Recommendation:	20. SJA Signature:

Warning: Information contained in this document is protected by the Privacy Act (5USC 552a)

WISCONSIN NATIONAL GUARD
ACCOMMODATION MEDICAL INQUIRY FORM

I,_____, have requested an accommodation of

_____ (describe accommodation) because

of functional limitations of my disability.

To Employee: It has been determined by the Agency there is a need for additional medical information in order to effectively identify the most appropriate accommodation(s) for you. This form is to be completed by a physician or care provider. Completed forms are to be returned to: Disability Program Manager, ng.wi.wiarng.mbx.eo-disability-program@army.mil, or 2400 Wright Street, Madison, WI 53704. For assistance or questions, regarding this process please contact the WING Disability Program Manager at 608-242-3701.

Any information collected on this document and throughout the interactive accommodation process will be kept confidential in accordance with the Rehabilitation Act and applicable laws/regulations. Collected information will be kept in files separate from personnel files.

Requesting an accommodation and participating in the interactive process is a protected activity, and WING employees will not be retaliated against for engaging in the process. Any employee who believes they have experienced retaliation for participating in this process should contact the WING Equal Opportunity Office at 608-242-3702 within 45 days of the alleged retaliation or knowledge of the alleged retaliation.

Release of Information

I hereby authorize the release of the following information to the WING for the purpose of determining the availability of reasonable workplace accommodation(s) in accordance with the Rehabilitation Act of 1973. I understand if the WING needs supplemental information, the Agency may ask me to sign an additional limited release and either submit a list of questions to my health care professional or have the Agency's own physician contact my health care provider. I have the right to revoke this authorization at any time. This release of information will expire within 60 days of signature.

_____ _____

Employee Signature Date

Provide this form and a copy of your employee position or job description to your Health Care Practitioner.
The remainder of this form should be completed by your Health Care Practitioner with your consult.

To Health Care Practitioner: Your patient named above, has requested a disability accommodation (described above) because of functional limitations caused by their disability.

An accommodation is a modification made to a job and/or work environment to enable a qualified employee/applicant with a disability to successfully perform the essential duties or functions of the position.

The questions below seek a response as to the nature, severity, and duration of the impairment, the activity the impairment limits, the extent to which the impairment limits the employee's ability to perform the activity and should also substantiate why the requested reasonable accommodation is needed. Please limit your responses to the conditions for which the employee/applicant is seeking an accommodation.

A. Questions to help determine whether an employee has a disability.

For reasonable accommodation under the ADA, an employee has a disability if they have 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:

1. Does the employee have a physical or mental impairment?	Yes ☐	No ☐

2. If yes, what is the nature of the impairment?

Note: *Some state laws may prohibit asking for a diagnosis.*

B. Questions to help determine accommodation needs and effective solutions.

Answer the following question based on what limitations the employee has when their 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, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary hearing aids, eyeglasses or contact lenses.

1. Does the impairment substantially limit a major life activity as compared to most people in the general population?		Yes ☐	No ☐
2. Please identify the severity and duration of the impairment.	Permanent ☐	Long-Term ☐	Short-Term ☐

C. Instructions:
The following table indicates the major life activity that is affected by the applicant/employee's medical condition. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. Indicate only the major activity affected by the applicant/employee's medical condition by circling or checking the appropriate block. Indicate the specific limitation of the applicant/employee resulting from their condition. Quantify their limitation in order for the agency to determine appropriate workplace accommodations (1-2 hours, 100 feet, 75% of day, or another notation).

Activity (circle all that apply or fill in)	**Extent of Limitation**	**Detailed Explanation/Recommendation**
Sensory: - Seeing/vision ☐ - Hearing ☐	Limited to:	
Breathing/Respiratory ☐	Limited to:	
Speaking ☐	Limited to:	
Basic Mobility - Walking ☐ - Climbing stairs ☐ - Sitting ☐ - Standing ☐	Limited to: ☐ Hours per day ☐ Distance ☐ % of day	
Secondary Mobility - Squatting/kneeling ☐ - Twisting (neck/waist) ☐ - Bending/stooping ☐ - Reaching above shoulders ☐	Limited to: Hours per day	
Physical Exertion - Pushing/pulling ☐ - Lifting/carrying ☐	Limited to: # of pounds	
Fine Motor Skills - Keyboard use ☐ - Repetitive use of hands ☐ - Grasping ☐ - Fine finger motions ☐	Limited to: Hours per day	
Cognitive - Thinking ☐ - Learning ☐ - Comprehending ☐ - Concentrating ☐	Limited to:	
Caring For Self - Self-medication/checks ☐ - Dressing ☐	Limited to:	
Mental/Emotional ☐	Limited to:	
Sleeping ☐	Limited to:	
Other/Bodily Functions ☐	Limited to:	

Other information or comments.

Health Care Practitioner's Information:

Print Name: Title/Specialty:

Phone: Clinic/Organization:

Signature: Date:

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.