Interactive Disability Accommodation Document

Confidential

This form is to be used by department HR Representatives to record the result of the conversation between the employee or applicant with a disability and the department as to a reasonable accommodation required for the individual to have opportunity for safe and effective performance of the essential job functions of the specific position. HR Representatives and supervisors are encouraged to establish a regular and consistent review with the employee of the accommodation's success.

Equipment or other material accommodations obtained by the department are the property of the department. Should the employee obtain another position with the University, this accommodation does not follow into the new position. All disability accommodation documents are to be submitted to University Faculty and Staff Disability Services and the employee should request accommodation with the new department, if needed.

If a reasonable accommodation agreement is not reached, the employee may file a request for review with University Faculty and Staff Disability Services.

This form is filed in the employee's medical file separate from the personnel file and must be treated with strict confidentiality.

Employee Name _____ Agreement Date _____

Job Title _____ Org/Department _____

Supervisor Name _____

1. List the limitation and duration: _____
2. List the job task(s) impacted and how/why:

3. List the accommodation that will allow the employee opportunity to perform this job task. If the task is part of a marginal function and no accommodation exists, record the function that will be eliminated and attach EMJFA/job description:

4. Cost of accommodation: $ _____
5. Employee Agreement with Accommodation: ◯ Yes ◯ No

Employee Signature _____

Signatures Below Indicate Agreement with Accommodations

Employee Supervisor _____ Date _____

HR Representative _____ Date _____

Senior HR Leader _____ Date _____

Departmental Executive Officer (as applicable) _____ Date _____

For additional accommodations, please see page 2.

Obtain Supervisor signature prior to attaching confidential medical information. Send completed form with medical documentation to: FSDS fsds@uiowa.edu or 121-20 USB. FSDS staff will forward copies of the completed form to the employee and designated HR staff member.

Additional Job Tasks Impacted and Accommodation

1. List the limitation and duration: ______________________
2. List the job task(s) impacted and how/why:
3. List the accommodation that will allow the employee opportunity to perform this job task. If the task is part of a marginal function and no accommodation exists, record the function that will be eliminated and attach EMJFA/job description:
4. Cost of accommodation: $ __________
5. Employee Agreement with Accommodation: ◯ Yes ◯ No

   Employee Signature ______________________

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3. List the accommodation that will allow the employee opportunity to perform this job task. If the task is part of a marginal function and no accommodation exists, record the function that will be eliminated and attach EMJFA/job description:
4. Cost of accommodation: $ __________
5. Employee Agreement with Accommodation: ◯ Yes ◯ No

   Employee Signature ______________________

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3. List the accommodation that will allow the employee opportunity to perform this job task. If the task is part of a marginal function and no accommodation exists, record the function that will be eliminated and attach EMJFA/job description:
4. Cost of accommodation: $ __________
5. Employee Agreement with Accommodation: ◯ Yes ◯ No

   Employee Signature ______________________