CS-1668
REV 7/2020

AUTHORITY: Article 11, §5, Michigan Constitution of 1963, CSC Rule 1-8, and Regulation 1.04.

DISABILITY ACCOMMODATION REQUEST AND MEDICAL STATEMENT

SECTION I – FOR COMPLETION BY EMPLOYEE. Please fully answer each item on the front of this form, in accordance with the attached instructions. Then provide the form, **together with a copy of your position description**, to your medical professional to complete the back of the form. Return the completed form to your departmental Accommodation Coordinator or other designated official. The information you submit will be treated as confidential to the extent permitted by law. Please note that **your request cannot be processed unless both sides of this form are completed**. For further information, refer to Civil Service Regulation 1.04, "Reasonable Accommodation."

1. Name	2. Employee's Identification Number	3. Department/Agency
4. Working Title	5. Civil Service Classification	6. Bargaining Unit (if any)
7. Work Address (home address if on leave)		8. Telephone Numbers Work Home

9. Describe your current job duties requiring an accommodation because of a disability. (To facilitate the timely consideration of your request, **please attach a copy of your position description** when submitting this form. If you do not have a copy of your position description, please contact your human resources office or accommodation coordinator for one.)

10. My disability is (Check as appropriate.) ☐ **Mental** ☐ **Physical** ☐ **Both**

11. Describe the functional limitations caused by your disability for which you are requesting an accommodation. Use additional pages, if necessary. (Attach any additional medical documentation.)

12. Describe any accommodations that you believe would minimize or eliminate the functional limitations listed above. Include any available information relating to cost, source, name of device, etc.

13. Date Submitted	14. Name and phone number of Immediate Supervisor	15. Employee's Signature

SECTION II – FOR COMPLETION BY MEDICAL PROVIDER. Please fully answer all applicable parts, based on your medical knowledge, experience, and examination of the patient. The employee should provide you with a copy of their position description. The following sections of the position description should be referenced when completing this form: job duties, physical effort, and essential functions. Please attach additional sheets if more space is needed. When completed, please sign and return the form to the patient so that he or she may submit it to their employer.

16. Health Care Provider's Name and Business Address	**17. Telephone Number**

18. Does this employee have a physical or mental impairment? ☐ **Yes** ☐ **No**. (If yes, state the type of impairment.)

19. List each major life activity limited by the impairment and describe how the employee is restricted due to the condition, as compared to an average person.

20. What is the duration or expected duration of the employee's impairment?

21. Can the employee perform all job duties listed in the job description? ☐ **Yes** ☐ **No**. (If no, state which job functions cannot be performed and why.)

22. Describe any reasonable accommodations that would allow the employee to perform the job functions listed above. If medical leave is one of the possible accommodations, please provide an estimated duration for the leave.

23. Would performing any job function listed in the job description result in a direct safety or health threat to the employee or other people (coworkers, the general public, etc.). ☐ **Yes** ☐ **No**. (If yes, state which job functions would pose a threat, what that threat could be, and any reasonable accommodation that would eliminate or reduce the threat to an acceptable level.)

24. Medical Provider's Signature	**25. Date**

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INSTRUCTIONS FOR COMPLETING THE DISABILITY ACCOMMODATION REQUEST FORM

(Consult your department's accommodation coordinator or other designated official for assistance, if necessary.)

Questions	Instructions
Questions 1-8	Complete all personal information that is applicable.
Question 9	Describe which job duties you are (or anticipate) having difficulty performing because of your disability. A current Position Description (CS-214) must be attached. Contact your personnel office if you were not given a copy.
Question 10	Indicate whether the nature of your disability is mental, physical, or both.
Question 11	Describe the functional limitations of your disability which interfere (or may interfere) with performing the duties of your job. Please attach medical documentation regarding your disability and functional limitations.
Question 12	Describe the accommodations you are requesting. Please provide alternative accommodation suggestions, where possible. Include past accommodations, if relevant, and any specific information relating to cost, source, name of device, etc., that you may have.
Question 13	Enter the date you submit this completed form.
Question 14	Enter the name and phone number of your immediate supervisor.
Question 15	Sign the form. If you are unable to sign the form, your designated representative may sign on your behalf.
Questions 16 through 25	After completing the front of the CS-1668, you must provide the form, **together with a copy of your position description**, to your medical provider, to complete the back of the CS-1668 and return the completed form to you for final submission.

FILING BY EMPLOYEE

Once completed, make a copy of this form. Keep a copy of the form and submit the signed original to your department's accommodation coordinator or other designated official.

RESPONSE TIME

You should receive a final response to your request within eight weeks after your completed request is received. If necessary, follow up with your Accommodation Coordinator or other designated official.

APPEAL

If you are dissatisfied with the final response of the accommodation coordinator or the accommodation coordinator fails to issue a final response within eight weeks, you may appeal through the appropriate departmental process, grievance procedure, or take other action as authorized by law.

CONFIDENTIALITY

Information in your request will be held confidential to the extent allowed by law. Information obtained or generated in processing your request may be released to individuals or agencies participating in the evaluation of your request.