

# Procedure: 4.6.2p.

## Reasonable Accommodations in Employment

**Revised:** October 25, 2022; and October 19, 2020.

**Last Reviewed:** October 25, 2022; and September 12, 2013.

**Adopted:** September 12, 2013.



### I. PURPOSE:

The Technical College System of Georgia (TCSG) is committed to equal opportunity in all aspects of employment for qualified individuals with a disability. Pursuant to the provisions of applicable state and federal law, it is the policy of the TCSG to provide reasonable accommodations in the hiring and employment of qualified individuals with a disability. Consistent with the ADA, this procedure utilizes a broad definition of disability to promote access to reasonable accommodations for all qualified individuals experiencing physical or mental impairments. Each accommodation request will be reviewed on a case-by-case basis in a flexible, prompt, and efficient manner. Accommodation will be provided where appropriate and may differ based on an individual's medical condition, medical treatment, and the job duties of the position they hold or desires to hold. Retaliation against an individual with a disability for utilizing the provisions of this procedure is expressly prohibited.

### II. RELATED AUTHORITY:

Americans with Disabilities Act (ADA) of 1990, as amended.  
Rehabilitation Act of 1973, as amended.  
Genetic Information Nondiscrimination Act (GINA) of 2008.

### III. APPLICABILITY:

All work units and Technical Colleges that are associated with the Technical College System of Georgia.

### IV. DEFINITIONS:

- A. **Accommodation (or Reasonable Accommodation):** a change to how things are typically done at work to help an applicant or employee with a disability apply for a job, perform job duties, or enjoy job benefits.
- B. **Disability:** a physical or mental disorder, illness, or condition ("impairment") that substantially limits one or more major life activities or primary bodily functions; a record (history) of having such an impairment; or being regarded as having such an impairment.
- C. **Essential Functions:** the fundamental job duties of the position an individual with a disability holds or desires to hold.
- D. **Interactive Process:** an informal, confidential dialogue between an applicant or employee with a disability and a human resources representative (or another management official of

the System Office or Technical College) concerning a request for a reasonable accommodation. The interactive process involves: (1) analyzing the position to determine its essential and marginal functions; (2) identifying the individual's job-related limitation(s); (3) identifying potential accommodation(s) that would enable the individual to perform the essential functions of the position; and (4) selecting and implementing the most appropriate accommodation.

- E. **Major Life Activity:** activities which include, but are not limited to, (1) caring for one's self, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, speaking, breathing, learning, eating, sleeping, bending, reading, communicating, and working; (2) mental and emotional processes such as thinking, concentrating, and interacting with others; and (3) the operation of primary bodily functions to include the immune system, average cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.
- F. **Marginal Function:** a job duty considered a secondary or non-critical task or activity.
- G. **Qualified Individual with a Disability:** an applicant or employee with a disability who satisfies the requisite skill, experience, education, and, if applicable, other job-related requirements for the job/position s/he holds or desires to hold and who can, with or without reasonable accommodation, perform the essential functions of the job/position.
- H. **Regarded as Having an Impairment:** individuals who are "regarded as having such an impairment" are subjected to a prohibited employment action because of an actual or perceived physical or mental impairment, whether or not the impairment limits or is perceived to limit a significant life activity.

## V. ATTACHMENTS:

Attachment: 4.6.2p.a1. Reasonable Accommodation Request Form

Attachment: 4.6.2p.a2. Medical Information Request Letter

Attachment: 4.6.2p.a3. Medical Information Request Form

Attachment: 4.6.2p.a4. Authorization for Release of Information Form

Attachment: 4.6.2p.a5. Interactive Disability Accommodation Document

Attachment: 4.6.2p.a6. Essential and Marginal Job Function Analysis Worksheet

Attachment: 4.6.2p.a7. Reasonable Accommodation Review Form

## VI. PROCEDURE:

### A. Initiating the Reasonable Accommodation Process:

1. The process begins when an applicant or employee makes a verbal or written request for reasonable accommodation to a System Office or Technical College representative (e.g., a manager or supervisor, human resources staff member, etc.). It is permissible for a family member, friend, health care provider, or another representative to initiate a reasonable accommodation request on behalf of an applicant or an employee with a disability. Any such request need only indicate that the applicant/employee requires assistance in the application process, a work-related change or adjustment to the work environment, or a change to the manner or circumstances under which the position is customarily performed due to a disability. To request accommodation, an individual may use plain language and does not need to mention the ADA, use the terms "disability" or "accommodation," or use the phrase "reasonable accommodation."
2. Upon receipt of this information, the applicant/employee will be provided with a Reasonable Accommodation Request Form (Attachment: 4.6.2p.a1) to complete if s/he has not already done so. However, completing that form is not necessary or required to begin the interactive process, which begins when the applicant/employee makes the request (oral or written). For example, suppose an applicant/employee

does not complete the form or is unable to complete the form due to their disability. Then, if needed, the System Office or Technical College representative may complete the form in consultation with the employee/applicant.

3. As applicable, the completed form should be forwarded by the applicant, employee, or other individual acting on the applicant/employee's behalf to the System Office or Technical College office of human resources.

**B. System Office/Technical College Responsibilities:**

1. Upon receipt of the completed Reasonable Accommodation Request Form (or in response to a written or verbal request) in the System Office or Technical College human resources office, staff should first locate a copy of the relevant job description.
2. A request for medically related documentation will not be initiated when both the disability and the need for reasonable accommodation are apparent or when the applicant/employee has already provided the System Office or Technical College with sufficient information to substantiate that s/he has a disability and needs the accommodation requested.
3. When an applicant/employee's disability and/or need for an accommodation is not visible, apparent, or otherwise known, a human resource representative responsible for overseeing the interactive process may request that the applicant/employee obtain medical documentation from their treating health care provider.
4. In these circumstances, the applicant/employee will be provided with a Medical Information Request Letter, including a reasonable time frame of no less than thirty (30) days for completion and submission of the requested information (Attachment: 4.6.2p.a2.), as well as a Medical Information Request Form (Attachment: 4.6.2p.a3), an Authorization for Release of Information Form (Attachment: 4.6.2p.a4), and a copy of the relevant job description (if available), with instructions regarding completion and submission of these documents to their treating health care provider.
5. The scope of requested medical documentation must be limited to information that supports the specific request for reasonable accommodation. The applicant/employee and their health care provider may also submit this information in a different format, such as a doctor's note, so long as it provides the needed information. The form may help facilitate the process but will not be required.
6. Within thirty (30) calendar days of receipt of the completed appropriate accommodation form and requested medical information (if applicable), or sooner if possible or circumstances require, the System Office or Technical College office of human resources must notify the applicant/employee in writing whether their request has been approved or denied, what accommodations will be provided, and the timeframe for providing the accommodations.

**C. Applicant/Employee Responsibilities:**

1. As referenced in Paragraph VI.B.3, an applicant/employee may be asked to obtain medical documentation from their healthcare provider in conjunction with a request for reasonable accommodation.
2. In these circumstances, the applicant/employee is responsible for obtaining the information within the period referenced in the accompanying Medical Information Request Letter. The applicant/employee and/or their health care provider must notify the System Office or Technical College if additional time is needed to gather the requested medical information.
3. The applicant/employee may limit the period and/or scope of their authorization for releasing information to such information that is necessary and relevant to the

applicant/employee's request for reasonable accommodation. The System Office or Technical College will consider the reasonable accommodation request within this limited basis and/or work with the applicant/employee to obtain additional information needed to evaluate the request.

4. An applicant/employee whose request for an accommodation has been denied or who is otherwise not satisfied with the accommodations provided or the accommodation process may request a review of the decision by TCSG's Office of Legal Services using the process outlined in Paragraph VI.G. of this procedure.

**D. Identification of Possible Reasonable Accommodations:**

1. The results of conversation(s) with the applicant/employee regarding potential reasonable accommodations will be documented using Attachment: 4.6.2p.a5 (Interactive Disability Accommodation Document) will be provided to the applicant/employee upon request.
2. The human resources representative responsible for overseeing the interactive process should actively dialogue with the applicant/employee to identify adequate, reasonable accommodation in each circumstance. Suggestions from the applicant/employee with a disability are encouraged and may assist the System Office or Technical College in determining the type of accommodation to provide. However, the applicant/employee is not required to suggest specific accommodations. In instances where the individual and the System Office or Technical College are unfamiliar with possible accommodations, the System Office or Technical College may need to consult public and/or private sector resources to help identify possible accommodations. In doing so, the System Office or Technical College will not disclose any personally identifying or protected health information about the applicant/employee.
3. Possible accommodations for a current employee include, but are not limited to: job restructuring; the transfer of marginal job functions to another employee; reassignment to a vacant position; ergonomic adjustments; time off for medical appointments; acquisition or modification of work tools, equipment, or devices; a part-time or modified work schedule; assistive devices; appropriate adjustment or modifications of examinations, training materials, or policies; the provision of qualified readers or interpreters; a modification of existing facilities used by employees to ensure that the workplace is readily accessible to and usable by individuals with disabilities; and/or other similar accommodations for individuals with disabilities.
4. Possible accommodations for an applicant include modification(s) or adjustment(s) to the job application process that better enable a qualified applicant with a disability to be considered for the applicant's desired position.
5. When more than one possible reasonable accommodation is available that effectively addresses the needs of an applicant or employee with a disability, the System Office or Technical College may select the accommodation to be offered, provided, however, that the preference of the applicant/employee with a disability will be given primary consideration.
6. Suppose a request for reasonable accommodation request is subsequently approved. In that case, the approval parameters shall be provided to the applicant or employee in writing by a representative of the System Office or Technical College office of human resources. All such decisions to approve or deny an accommodation request will be made no later than thirty (30) calendar days after receipt of an applicant/employee's completed request and, as applicable, receipt of all necessary medical documentation from their health care provider, or sooner where possible or

circumstances require. The applicant/ employee must be notified in writing (prior to the expiration of the thirty (30) day period) if additional time is needed to review all associated materials about the requested accommodation.

**E. Assessment of Undue Hardship:**

1. The TCSG and its associated Technical Colleges must provide reasonable accommodations to qualified individuals with a disability who are employees or applicants for employment unless doing so would cause undue hardship. Such determinations are made on a case-by-case basis. Before making any such determination, the System Office or Technical College should consult TCSG's Office of Legal Services or Director of Human Resources to discuss this and other alternatives to address the employee/applicant's request for accommodations.

**F. Review Procedure:**

1. An applicant/employee whose request for an accommodation has been denied or who is otherwise not satisfied with the accommodations provided or the accommodation process may request a review of the decision by TCSG's Office of Legal Services using the Reasonable Accommodation Review Form (Attachment: 4.6.2p.a9). Any such request for review must be initiated within ninety (90) calendar days of receipt of the System Office or Technical College's written determination of the accommodation request.
2. The Office of Legal Services will review all associated documentation and may, if needed, meet with the applicant/employee, the System Office/Technical College official(s), and/or others with knowledge of the situation. The System Office or Technical College human resources office must provide the applicant/employee's original reasonable accommodation request and supporting documentation upon request by the Office of Legal Services. The Office of Legal Services will generate a written decision within fifteen (15) calendar days after receipt of the request unless additional time is needed to complete the review. In this latter circumstance, the requesting applicant/employee and the System Office management official or Technical College president shall be notified of the needed extension in writing.
3. During the review period, the System Office or Technical College should not implement any modifications that would negatively impact an applicant/employee, and the applicant/employee may remain at work if there are duties/tasks which can be performed within the parameters of medically documented restrictions.
4. The decision by the Office of Legal Services will be final and conclude TCSG's reasonable accommodation process for any review initiated through this procedure.
5. Complaints related to the interpretation or application of this procedure must be filed using the process outlined in Procedure 4.4.3p, Employee Complaint Resolution.
6. Applicants/employees may also file a complaint regarding the reasonable accommodation process and outcome or any other form of disability discrimination with the U.S. Equal Employment Opportunity Commission (EEOC). TCSG and its associated Technical Colleges will not retaliate against an applicant/employee for requesting accommodation, filing an appeal, grievance, or complaint, or otherwise exercising their rights under this policy or the law.

**G. Implementation of the Reasonable Accommodation:**

1. After System Office or Technical College approval, an approved reasonable accommodation should be implemented as quickly as possible. Should the accommodation require the purchase of equipment or additional training, this should be completed promptly to ensure timely implementation and may require the System

Office or Technical College to provide temporary accommodation(s) until the approved accommodation is implemented.

2. During the reasonable accommodation process, an employee is not to be assigned duties/tasks that exceed the restrictions documented by their healthcare provider.

**H. Monitoring the Effectiveness of the Reasonable Accommodation:**

1. The interactive process is an ongoing obligation of the Technical College System of Georgia. Therefore, if the employee states that a given accommodation is inadequate or no longer adequate, the System Office or Technical College must continue to engage in discussions to identify other possible alternatives or, as appropriate, additional accommodation(s).
2. Any subsequent change to an employee's health condition or modifications impacting workplace factors may warrant a re-evaluation of the provided accommodation(s) using, where appropriate, one or more steps referenced in this Procedure.

**I. Confidentiality of Reasonable Accommodation Documentation:**

1. All documentation associated with a request for reasonable accommodation, including, but not limited to, correspondence, completed forms, and submitted medical information, shall be maintained confidentially and housed separately in a locked compartment. For employees, these materials shall be maintained in their medical files.
2. Access to non-medically related information shall be limited only to those System Office or Technical College employees with a "need to know."
3. Medical documentation obtained through the reasonable accommodation process is considered a confidential medical record. Therefore, such documents are restricted only to the human resources representative(s) overseeing the interactive process.
4. Concerning a request for accommodation by a current employee, supervisors, managers, and other designated System Office or Technical College officials may only be informed of the identified work-related restrictions and the recommended accommodations, if any, and only if they need to know. First aid and safety personnel, as well as the employee's immediate supervisor, may be provided with additional information about the disability if there is a possibility that emergency treatment could be required.

**VII. RECORD RETENTION:**

All documentation, forms, etc., obtained during the reasonable accommodation process for current employees and applicants subsequently hired shall be maintained in the employee's medical file.

All documentation, forms, etc., obtained during the reasonable accommodation process for an applicant for employment not subsequently employed shall be maintained confidentially in a separate locked compartment for two (2) years.

**Attachment 4.6.2p.a1.**

**TECHNICAL COLLEGE SYSTEM OF GEORGIA  
Reasonable Accommodation Request Form**

This form is designed to assist the Technical College System of Georgia's (TCSG) System Office or \_\_\_\_\_ Technical College in determining whether, or to what extent, a reasonable accommodation is required for an individual with a disability to apply for or perform a job/position, or to enjoy equal employment opportunities, benefits, and privileges as other employees without disabilities. NOTE: The completed form will be filed separately and treated confidentially.

**SECTION I. Applicant/Employee Information:**

Applicant/Employee Name: \_\_\_\_\_  
(Please Print)

Street Address/P.O. Box: \_\_\_\_\_

City/State: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Job/Position Title: \_\_\_\_\_ Request Date: \_\_\_\_\_

As Applicable, Supervisor Name: \_\_\_\_\_

By my signature below, I understand that all information obtained during this process will be maintained and used following the ADA and all corresponding legal and regulatory medical and genetic information requirements and associated confidentiality.

\_\_\_\_\_  
Applicant/Employee Signature

\_\_\_\_\_  
Date

**SECTION II:**

Please answer the following questions to assist the System Office or Technical College in understanding the basis and nature of your request for reasonable accommodation (attach additional pages if necessary).

- A. Briefly describe the medical condition(s) or disabilities that require reasonable accommodation, including the expected duration of each. NOTE: it is not necessary to indicate a medical diagnosis or condition.

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- B. Explain how the disabilities or conditions described above affect your ability to apply for a job, perform your duties, or access an employment benefit.

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- C. Describe the accommodation(s) you are requesting. If unsure of what to request, please note the type of assistance that is needed.

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- D. Has a physician or other medical or rehabilitation provider/professional recommended one or more specific accommodation(s)?    YES \_\_\_    NO \_\_\_

If yes, please attach a copy of the recommendation(s).

Please forward the completed form with any accompanying attachments to the following:

[Name/Title]: \_\_\_\_\_  
[System Office/Technical College]: \_\_\_\_\_  
[Street Address]: \_\_\_\_\_  
[City/State/Zip Code]: \_\_\_\_\_



Attachment 4.6.2p.a2.

**TECHNICAL COLLEGE SYSTEM OF GEORGIA**  
**Medical Information Request Letter**

**[DATE]**

**[Applicant/Employee Name]**

**[Address]**

RE: Request for Medical Documentation

Dear **[Name]**:

You recently requested reasonable accommodation. To assist the Technical College System of Georgia (TCSG) and our office in evaluating your request and identifying accommodations, additional medical information is needed from your treating healthcare provider (or other provider/professional). Please be advised that the accommodation procedures of TCSG follow the Americans with Disabilities Act, and additional information is needed to continue the interactive process that TCSG must engage in with you.

The health information provided by your provider is considered confidential and only information necessary to implement a reasonable accommodation will be shared with **[the employee's supervisor or the supervisor of the position applied for]** and, as applicable, **[the reviewing manager or other designated officials]**. All written documentation accompanying your request, including associated medical information, will be maintained separately and treated confidentially. The documents will be placed in your medical file, separate from your official personnel file.

Please discuss your health concerns regarding your assigned job duties with your treating healthcare provider. I am sharing the following documents to assist your provider in reviewing your request for accommodation: the Medical Information Request Form, your completed Authorization for Release of Information Form, and the accompanying job/position description.

Please have your treating healthcare provider respond to the attached Medical Information Request Form questions. Then, please return the completed form to me no later than **[Insert Date: thirty (30) calendar days from the date of the letter.]**

I encourage you and/or your treating healthcare provider to contact me with any questions regarding this process, the accompanying Medical Information Request Form, or if additional time is needed to gather the requested information/documentation.

Sincerely,

**[Human Resources Representative]**

Enclosures: Medical Information Request Form  
Authorization for Release of Information Form  
Job/Position Description

CC:

**Attachment 2.6.2p.a3.**

**TECHNICAL COLLEGE SYSTEM OF GEORGIA  
Medical Information Request Form**

Section I: (For Completion by Human Resources Representative)

Applicant/Employee Name: \_\_\_\_\_

The [position entails/employee works] a regular schedule of \_\_\_\_\_ hours per day, averaging \_\_\_\_\_ per week.

Return the completed form to:

\_\_\_\_\_ Human Resources Representative  
\_\_\_\_\_ [TCSG System Office or Technical College]

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Section II: (For Completion by Treating Health Care Provider/Professional)

What is the physical or mental condition for which the individual requests accommodation? \_\_\_\_\_

Are you a treating health care provider/professional? Yes \_\_\_\_\_ No \_\_\_\_\_

Please identify the major life activities and/or bodily functions below that are limited due to the health condition or impairment(s), the treatment for the health condition or impairment(s), and/or the side effect(s) of medication(s) for the health condition or impairments(s) for which the individual is requesting an accommodation.

Limitation in the number of hours worked:

\_\_\_\_\_ Work no more than \_\_\_\_\_ hours per week  
\_\_\_\_\_ Work no more than \_\_\_\_\_ hours per week

Frequently = 34% to 66% of the time – Occasionally = 1% to 33% of the time:

_____ Lift up to _____ pounds	_____ Frequently	OR	_____ Occasionally
_____ Push/pull/force _____ pounds	_____ Frequently	OR	_____ Occasionally
_____ Bend, twist, stoop	_____ Frequently	OR	_____ Occasionally
_____ Reaching	_____ Frequently	OR	_____ Occasionally

During Work Hours

\_\_\_\_\_ Stand no more than \_\_\_\_\_ hours  
 \_\_\_\_\_ Walk no more than \_\_\_\_\_ hours  
 \_\_\_\_\_ Sit no more than \_\_\_\_\_ hours

Additional Major Life Activities

___ Walk	___ Stand	___ Sit	___ Reach	___ Lift	___ Bend
___ Concentrate	___ Think	___ Hear	___ Learn	___ Perform Multiple Tasks	
___ Interact with Others	___ Sleep	___ Eat	___ Read	___ Communication	
___ Work	___ Sight	___ Breathe	___ Speak	___ Caring for Oneself	

Other: \_\_\_\_\_

Other Major Bodily Functions (Please Select)

Major Bodily Functions	Special Sense Organs and Skin	Normal Cell Growth	Lymphatic
___ Immune System	___ Bowel	___ Bladder	___ Digestive
___ Genitourinary	___ Respiratory	___ Circulatory	___ Neurological
___ Brain	___ Hemic	___ Lymphatic	___ Cardiovascular
___ Endocrine	___ Other: _____	___ Other: _____	___ Musculoskeletal
___ Reproductive			___ Other: _____

Please Provide Details:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is the impact on the individual's ability to perform their job?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is the expected duration of the limitation(s) pertaining to the major life activity and/or bodily function for which the individual requests accommodation?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Office Name of the Treating Healthcare Provider/Professional      Treating Health Care  
Provider/Professional (Printed Name)

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Treating Health Care Provider/Professional (Signature)      Date

NOTE: 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 an individual, except as permitted by law. To comply with these provisions, we request that you do not provide genetic information when responding to this request for medical information. "Genetic Information" is defined as 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.

**Attachment 4.6.2p.a4.**

**TECHNICAL COLLEGE SYSTEM OF GEORGIA  
Authorization for Release of Information Form**

For Completion by Applicant/Employee

I, \_\_\_\_\_ authorize \_\_\_\_\_ of  
Applicant/Employee Name (Please Print) Health Care Provider/Professional (Please Print)

\_\_\_\_\_ to discuss, disclose and/or provide the specific  
Clinic/Medical Office (Please Print)

information referenced below to \_\_\_\_\_  
Human Resources Representative(s)

of \_\_\_\_\_ at the following  
mailing address:

TCSG System Office or Technical College

Applicant or Employee Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_  
Street/P.O. Box City State Zip Code

Telephone Number: \_\_\_\_\_  
(Home) (Work or Cell)

Covering the Following Periods of Health Care Services:  
From (date): \_\_\_\_\_ To (date): \_\_\_\_\_

The following information will be used to determine my employment accommodation needs:  
(Check and initial each applicable section)

\_\_\_\_\_ Medical (please specify which medical information may be released):  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Psychiatric (please specify which psychiatric information may be released):  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Psychological (please specify which psychological information may be released):  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this information will include the following, if applicable:  
(Check and initial each applicable section)

\_\_\_\_\_ Behavioral Health services/Psychiatric care and services

\_\_\_\_\_ Treatment from alcohol and/or drug abuse/dependency

Affirmation of Release:

By my signature below, I provide the named health care provider/professional permission to release the information I have selected on this form to the individual(s) I have identified and only for the purpose stated. Suppose additional information/documentation is required to assess my request for reasonable accommodation. In that case, I will coordinate with my treating physician or other medical/behavioral health or rehabilitation provider/professional to provide the requested information. I also authorize the designated human resources representative(s) to consult with the provider/professional as it pertains only to the information provided and within the scope of my authorization.

I understand that this release is valid only for six (6) months from the date of my signature. I understand that I may refuse to sign this authorization or revoke my authorization at any time for any reason. Any such revocation will take effect on the day it is received in writing by the TCSG System Office or \_\_\_\_\_ Technical College. I understand that any revocation or refusal to sign this authorization will affect my eligibility for benefits or my ability to obtain services or treatment from the named provider or professional. However, I also understand that any action on my part to deny access to information that is essential to the determination of reasonable accommodation(s) may affect the outcome of my request.

I further understand that the identified human resources representative(s) of the TCSG System Office or \_\_\_\_\_ Technical College who will receive this information are not a health care provider, a health plan, or a health care clearinghouse and may not be covered by federal privacy regulations.

However, I understand that all submitted documentation/information and this form will be filed separately and treated confidentially as required by law. Access to this documentation/information will be restricted only to those System Office or Technical College employees who need to be aware of the information to assess the reasonableness of the requested accommodation better and, as applicable, those employees responsible for overseeing the implementation of any accommodation. Access may also be given to first aid and safety personnel if the disability might require emergency treatment or to government officials investigating the System Office or \_\_\_\_\_ Technical College's compliance with the ADA. If I am an employee, I understand that these documents will be placed in my medical file, which is maintained separately from my official personnel file.

\_\_\_\_\_  
Applicant/Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
(Relationship to Applicant/Employee)

\_\_\_\_\_  
Date

**TECHNICAL COLLEGE SYSTEM OF GEORGIA**  
**Interactive Disability Accommodation Document**

This form is to be used by the designated human resources representative to record the results of the conversation(s) between an applicant or employee with a disability and the System Office or employing Technical College as to a reasonable accommodation required for the individual to apply for or perform a job/position, or to enjoy equal employment opportunities, benefits, and privileges as other employees without disabilities. Equipment or other material accommodations obtained by the System Office or Technical College on behalf of the employee or applicant remain the property of the Technical College System of Georgia. A new request may be necessary if an employee transfers between System Office/Technical College work units.

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**NOTE: This form will be filed separately and is considered confidential. Access to this documentation/information will be restricted only to those System Office or Technical College employees who need to be aware of the information to better assess the reasonableness of the requested accommodation and, as applicable, to oversee the implementation of any accommodation. Access may also be given to first aid and safety personnel if the disability might require emergency treatment or to government officials investigating the System Office or Technical College's compliance with the ADA. For employees, the document will be placed in the respective medical file, which is maintained separately from each employee's official personnel file.**

Employee Name: \_\_\_\_\_ Agreement Date: \_\_\_\_\_

Job Title: \_\_\_\_\_ Work Unit: \_\_\_\_\_

In conjunction with the information obtained regarding the request for accommodation, list the limitation(s) and anticipated duration: \_\_\_\_\_

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List the job tasks/assigned duties/employment benefits or privileges that are impacted and how they are impacted by the referenced limitation(s):

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List the accommodation that will assist the employee or applicant in performing their job duties and enjoying equal employment opportunities, benefits, and privileges:

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As applicable, the monetary cost of the accommodation: \$\_\_\_\_\_

Applicant/Employee Agreement with the Accommodation: \_\_\_Yes \_\_\_No

If you marked “no,” please briefly explain what you disagree with and why:

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\_\_\_\_\_  
Applicant/Employee Signature

\_\_\_\_\_  
Date

**Signature below Indicate Agreement with Accommodation(s)**

\_\_\_\_\_  
Immediate Supervisor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Human Resources Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Commissioner/Technical College  
President or Designee

\_\_\_\_\_  
Date

NOTE: Immediate Supervisor’s signature should be obtained before confidential medical information is attached.

Please use Page 1 of the Attachment – complete and attach for additional accommodation.



**TECHNICAL COLLEGE SYSTEM OF GEORGIA**  
**Essential and Marginal Job Function Analysis Worksheet**

**SECTION I: Guidelines for Determining Essential versus Marginal Functions**

All TCSG System Office work units and all associated Technical Colleges are encouraged to complete an essential function analysis before advertising a vacant position and to use the information in the interviewing process, as appropriate. Job descriptions should include references to essential job functions, which apply to staff training and development activities and the performance appraisal/evaluation processes.

Under the Americans with Disabilities Act (ADA), an employer is generally required to make reasonable accommodations to the physical or mental limitations of an applicant/employee with a disability who can perform the job's essential functions, with or without reasonable accommodation.

Nonessential functions categorized as marginal or secondary are not to be used as the basis for an employment decision. Unlike an essential job/position function, a marginal function is relatively incidental to why the position exists. Also, unlike an essential function, a marginal function can be transferred to another position or performed a lesser percentage of the time without causing undue hardship to the employer. Although the task must be accomplished, it can be carried out by another employee or performed in less time.

Used properly, the Worksheet is an effective tool to ensure the accurate identification of both essential and marginal functions, the percentage of time required to perform job-related physical activities, the physical and cognitive requirements of the job/position, the equipment used, if any, and the accompanying environmental surroundings.

**SECTION II: Job/Position Information**

Position #: \_\_\_\_\_ Position Title: \_\_\_\_\_

Job Code#: \_\_\_\_\_ Work Unit: \_\_\_\_\_

Incumbent Name (if applicable): \_\_\_\_\_

**SECTION III: Position Summary**

Provide a brief position summary that describes the purpose of the position (please attach additional page(s) if needed):

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**SECTION IV: Essential Functions Analysis**

A separate checklist must be completed for each essential function of the position. Two checklists are provided in this section. Photocopy this page if additional checklists are needed.

**Essential Function:** \_\_\_\_\_

Question	Y/N	If yes, please explain
Must this employee perform this function?		
Can other current employees perform the function if this employee cannot?		
Would removing this function fundamentally change this job?		
Does the job exist to perform this function?		
Is special expertise or judgment required to perform this function?		
Would any significant consequences if this employee did not perform this function?		
Did the previous employee in this position perform this function?		
Do individuals doing similar work in this or other work units also perform this function?		
Must a vehicle be driven to perform this function?		
Hours per week spent performing this function:	N/A	

**Essential Function:** \_\_\_\_\_

Question	Y/N	If yes, please explain
Must this employee perform this function?		
Can other current employees perform the function if this employee cannot?		

Would removing this function fundamentally change this job?		
Does the job exist to perform this function?		
Is special expertise or judgment required to perform this function?		
Would any significant consequences occur if this employee did not perform this function?		
Did the previous employee in this position perform this function?		
Do individuals doing similar work in this or other work units also perform this function?		
Must a vehicle be driven to perform this function?		
Hours per week spent performing this function:	N/A	

**SECTION V: Job Analysis**

List each essential function of the position and complete the table with responses in each column. An example is provided to assist in your completion of this section.

	<b>Essential Function (EF)</b>	<b>% Time</b>	<b>Physical Aspects of EF</b>	<b>Mental Aspects of EF</b>	<b>Methods, Techniques, and Procedures for EF</b>	<b>Equipment, Tools, and Materials for EF</b>	<b>Working Conditions of EF</b>	<b>Supervision for EF</b>
<b>Ex.</b>	<i>Types of legal documents, correspondence, etc., from handwritten notes or dictation</i>	<i>10%</i>	<i>Sitting, typing, writing, walking</i>	<i>Editing, organizing, interpreting, processing</i>	<i>Typing, copying</i>	<i>Keyboard, computer screen, mouse, copier</i>	<i>1950s building; open office environment; employee works in close quarters with others in the shared secretarial area with no window, central heat/air, or air circulation; private offices that form a perimeter around the open secretarial area have individual heat/air units and doors that close and windows that open; small electric heaters and fans are available to all upon request.</i>	<i>General, receives instructions, work may be reviewed</i>
<b>1</b>								
<b>2</b>								

3								
4								
5								
6								
7								
8								
9								
10								

**SECTION VI: General Information:**

Location(s) where the work is performed: \_\_\_\_\_

Assigned work schedule: \_\_\_\_\_

Name of Immediate Supervisor: \_\_\_\_\_

Name and Title of Individual Completing this Worksheet: \_\_\_\_\_

Date: \_\_\_\_\_

**Attachment: 4.6.2p.a7.**

**TECHNICAL COLLEGE SYSTEM OF GEORGIA  
Reasonable Accommodation Review Form**

Review Process:

Suppose an employee or applicant's reasonable accommodation request has been modified or denied, and they disagree with the decision. In that case, they may request a review of the determination within ninety (90) calendar days of receiving written notice as follows:

Answer all questions on this form as accurately and thoroughly as possible;  
Attach documentation that supports your need for accommodation, as well as documentation of the System Office/Technical College decision;  
If available, attach a copy of your original request for reasonable accommodation and supporting documentation; and,  
Submit the completed form and supporting materials to:

Mr. Josh McKoon

General Counsel  
Technical College System of Georgia  
1800 Century Place NE, Suite 400  
Atlanta, GA 30345-4304  
Email: [jmckoon@tcsge.edu](mailto:jmckoon@tcsge.edu)  
Fax: 404-327-6932

Employee/Applicant Information:

Check One:                      \_\_\_\_\_ Employee                      \_\_\_\_\_ Applicant

Name (Please Print): \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_                      Cell Number: \_\_\_\_\_

System Office Work Unit/Technical College: \_\_\_\_\_

As Applicable, Name of Immediate Supervisor: \_\_\_\_\_

As Applicable, Current Job Title: \_\_\_\_\_

Date Accommodation(s) Requested: \_\_\_\_\_

Basis for Request for Review

I request a review of the decision regarding my request for a reasonable accommodation because:

\_\_\_\_ I was granted accommodation, but not the specific accommodation requested.

\_\_\_\_ I was granted accommodation, but not all of the accommodations requested.

\_\_\_\_ I was denied accommodation.

\_\_\_\_ Other. Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I believe that the decision made in response to my request for one or more accommodations was incorrect for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My signature below confirms that I have read and understood the Reasonable Accommodation Review Form, and I certify that the information provided is accurate to the best of my knowledge.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date