

TEXAS DEPARTMENT OF CRIMINAL JUSTICE

Workplace Accommodation Packet

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Texas Department of Criminal Justice

Brad Livingston
Executive Director

Dear Applicant or Employee:

The purpose of this packet is to assist you in applying for a workplace accommodation based upon your permanent or long-term medical condition. A workplace accommodation is any reasonable modification or adjustment that enables you to perform your essential job functions or participate in the application process. A workplace accommodation may take the form of restructuring the job, providing specialized equipment, making the workplace accessible, or providing additional time to take employee entrance examinations. In addition, if you are a current TDCJ employee, a workplace accommodation may include a reassignment to a vacant position for which you meet the minimum qualifications and are physically and mentally capable of performing. You are required to have a permanent or long-term medical condition and be able to perform the essential functions of your position with or without an accommodation to be eligible for a workplace accommodation. If you or your health care provider identifies a permanent or long-term medical condition limiting your ability to perform one or more of the essential functions of your job, the TDCJ shall attempt to reasonably accommodate you.

All positions have job related qualification standards consistent with business necessity. If it is determined you are currently unable to perform the essential functions of your job, you may be relieved of duty while a workplace accommodation is being sought.

If it is determined you have a permanent or long-term medical condition, Employee Relations, Human Resources Division, shall search for a reasonable workplace accommodation for a period of up to 90 calendar days. The 90 calendar days begin the day Employee Relations determines you have a permanent or long-term medical condition that makes you eligible for the Workplace Accommodation Program. If you are a current TDCJ employee and you are separated from employment within the 90 calendar days, such as exhaustion of all leave entitlements, the search for a reasonable workplace accommodation shall cease on the day of separation. The request shall then be administratively closed with no further action. Additionally, if a reasonable workplace accommodation is offered and refused, the request shall be administratively closed prior to the end of the 90 calendar days. If you are a current employee, refusal of an accommodation includes, but is not limited to: (a) declining the opportunity to visit the worksite of a potential job reassignment; or (b) declining to be reassigned to a position, for which you meet the minimum qualification, at the pay rate you indicated acceptable in this packet.

Our mission is to provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime.

2 Financial Plaza, Suite #600
Huntsville, Texas 77340-3558
(936) 437-3103
www.tdcj.texas.gov

The accommodation process shall not be initiated until all forms contained in the Workplace Accommodation Packet are completed and received by Employee Relations, Human Resources Division.

1. PERS 404-2, Request for a Reasonable Workplace Accommodation due to a Permanent or Long-Term Medical Condition.
2. PERS 404-4, Medical Information Form: In lieu of the PERS 404-4 form, you may submit a health care provider's statement on the health care provider's letterhead assessing the essential functions and what workplace accommodation(s) may be needed. The PERS 404-4 form or health care provider's statement shall be completed by your health care provider within 30 calendar days of the date you submit the completed packet to your human resources representative or the accommodation coordinator.

If a health care provider's statement is submitted in lieu of the PERS 404-4 form, the statement shall include: (a) the diagnosis and medical facts associated with the medical condition; (b) all limitations and restrictions; (c) whether the medical condition and the limitations and restrictions are permanent, long-term, or temporary; and (d) the extent, duration, or long-term effects of the impairment.

Submitting a request for an accommodation does not prohibit you from applying for other positions. All employees who can perform the essential functions are encouraged to apply for positions of higher pay for which they are qualified, with or without a reasonable accommodation.

If you have any questions, you may contact the accommodation coordinator in Employee Relations at (936) 437-3103. When you have completed the above items, you may fax the packet to the accommodation coordinator at (936) 437-4010 or submit the packet to your human resources representative. If you fax the packet to the accommodation coordinator, you are also required to send the original packet via first class mail or truck mail to the accommodation coordinator at the address listed below.

Human Resources Division
Employee Relations
2 Financial Plaza, Suite #600
Huntsville, Texas 77340-3558

Sincerely,

Section Director
Employee Relations

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Texas Department of Criminal Justice
Request for a Workplace Accommodation
Due to a Permanent or Long-Term Medical Condition

FOR AGENCY USE ONLY
Intake Number

To be completed by applicant or current employee:

Print Name: _____ Social Security Number: _____
Job Title: _____ Group or Monthly Salary Rate: _____
Unit/Dept.: _____

1. Describe the essential functions of the position applied for or your current job that you are unable to perform without special workplace accommodations:

2. Describe the physical or mental limitations(s) preventing you from performing these essential function(s):

3. Describe the workplace accommodation(s) you are requesting:

Personal Number: _____ (Area Code) Alternate or Cell Number: _____ (Area Code)

Mailing Address: _____
Street City State Zip Code

Email Address: _____

Signature: _____ Date: _____
(mm/dd/yyyy)

To be completed by current employee only: The following information is required in case it is determined that a job reassignment may be a reasonable workplace accommodation.

1. State your geographic preferences, indicating all units or areas where you are willing to work or relocate:

Lowest Acceptable Dollar Amount (Salary) per month: _____

2. Positions resulting in a promotion shall not be considered. During a maximum search period of 90 calendar days, a search for position reassignment will be conducted. The search will include a range between your current salary group and your lowest acceptable dollar amount. You must meet the minimum qualifications for any identified position. You may change the lowest acceptable dollar amount during the 90 calendar day period. If you accept a position at a lower salary group, you shall be reduced to the minimum rate of the designated salary group. Please indicate the **lowest** dollar amount per month that you are willing to accept. No offer shall be extended for a position below the dollar amount indicated. Once you have accepted or rejected a reasonable job offer, the search for a reasonable job reassignment is discontinued.

If the accommodation coordinator is unable to assist you or if the maximum accommodation search period of 90 calendar days expires, the accommodation coordinator shall notify the human resources representative that your request for an accommodation is being closed. The human resources representative shall advise you that you are required to comply with the TDCJ appropriate leave policy.

Note to Applicant or Employee: With few exceptions you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023 to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request in accordance with TDCJ procedures that incorrect information the TDCJ has collected about you be corrected.

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Human Resources Division
2 Financial Plaza, Suite #600
Huntsville, Texas 77340-3558

**Texas Department of Criminal Justice
Medical Information Form**

Please return this information to the accommodation coordinator via fax at (936) 437-4010 or mail to TDCJ, Employee Relations, 2 Financial Plaza, Suite #600, Huntsville, Texas 77340-3558.

Your Patient _____ SSN: _____ has applied for a workplace accommodation under the Texas Department of Criminal Justice's PD-14, "Americans with Disabilities Act and Employment of Persons with a Permanent or Long-Term Medical Condition." Attached is a copy of the job description, containing the Additional Requirements, such as physical or mental characteristics. Please provide the following requested information regarding those essential functions and characteristics based on your medical or psychological evaluation.

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. (75 Fed. Reg. 68934).

Diagnosis: _____

Date patient first diagnosed: _____ Date you first treated the patient for this condition: _____

Limitations and Restrictions: _____

Are these limitations and restrictions permanent or temporary? _____

Is this condition permanent, long-term, or temporary? _____

If the condition or restriction is temporary or long-term, please state the extent, duration, or long-term effects of the medical condition:

Date (mm/dd/yyyy)

() _____

Telephone Number

() _____

Fax Number

Health Care Provider Signature

Health Care Provider Printed Name

Street Address

City

State

Zip Code