TEXAS DEPARTMENT OF CRIMINAL JUSTICE

Accommodation Packet

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Texas Department of Criminal Justice

Bryan Collier
Executive Director

Dear Applicant or Employee:

The purpose of this packet is to assist you in applying for an accommodation based upon your disability. An accommodation is a reasonable modification or adjustment that enables you to perform your essential job functions or participate in the application process. An accommodation may involve job restructuring, specialized equipment, making the workplace accessible, or additional time to take employee entrance examinations. In addition, if you are a current TDCJ employee, an accommodation may include a reassignment to a vacant position for which you meet the minimum qualifications and you are physically and mentally capable of performing.

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

If you have a disability, the Employee Relations section, Human Resources Division, shall attempt to identify a reasonable accommodation for a period of up to 90 calendar days. The 90-day period begins the day the Employee Relations section determines you have a disability. If you are a current TDCJ employee and you are separated from employment for any reason during the 90-day period, the search for an accommodation shall cease. Additionally, if a reasonable accommodation is offered and refused, the request for accommodation shall be immediately terminated. 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.

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

1. PERS 404-2, Request for an Accommodation Due to a Disability.

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 the accommodation(s) that 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) whether the medical condition is permanent, long-term, or temporary; (c) all limitations and restrictions; (d) whether the limitations or restrictions are permanent, long-term, intermittent, or temporary; and (e) the extent, duration, or long-term effects of the impairment(s).

3. PERS 404-5, Authorization for Limited Release of Medical Information: The accommodation coordinator may require additional information from the health care provider. If sufficient medical information is not provided by you, the accommodation coordinator may need permission via a signed PERS 404-5 limited release permitting the accommodation coordinator to contact your health care provider.

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 any positions for which they are qualified, with or without a reasonable accommodation.

If you have any questions, you may contact the accommodation coordinator in the Employee Relations section 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

Texas Department of Criminal Justice
Request for an Accommodation Due to a Disability

FOR AGENCY USE ONLY
Intake Number

To be completed by applicant or current employee:

Print Name: _____ Social Security Number: _____

Job Title: _____ Unit/Dept.: _____

1. Describe the essential functions of the position applied for or your current job that you are unable to perform without special accommodations: (Attach additional pages as needed.)

_____

_____

2. Describe the physical or mental limitations(s) preventing you from performing these essential function(s): (Attach additional pages as needed.)

_____

_____

3. Describe the accommodation(s) you are requesting: (Attach additional pages as needed.)

_____

_____

Personal Number: _____ Alternate or Cell Number: _____
(Area Code) (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 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 may 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 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 will notify the human resources representative that your request for an accommodation is being closed. The human resources representative will advise you that you will be required to comply with the appropriate TDCJ 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.

Texas Department of Criminal Justice
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 an accommodation under the Texas Department of Criminal Justice's PD-14, "Americans with Disabilities Act and Employment of Persons with a Disability." Attached is a copy of the job description, which contains the essential functions of the position. Please provide the following requested information regarding those essential functions based on your medical or psychological evaluation.

Diagnosis: _____

_____

_____

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

What specific essential function(s) on the job description is limited or restricted? (Attach additional pages if needed.)

_____

_____

Is the medical condition permanent, long-term, or temporary? _____

Is the limitation or restriction permanent, long-term, intermittent, or temporary? _____

If the limitation or restriction is temporary, intermittent, or long-term, please state the extent, duration, or long-term effects of the medical condition: (Attach additional pages if needed.)

_____

_____

_____

_____
Date (mm/dd/yyyy)

_____
Health Care Provider Signature

( ) _____
Telephone Number

_____
Health Care Provider Printed Name

( ) _____
Fax Number

_____
Street Address

_____
City State Zip Code

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).

Texas Department of Criminal Justice

Authorization for Limited Release of Medical Information

I, _____ , authorize the Texas Department of Criminal Justice (TDCJ) accommodation coordinator or TDCJ official to receive medical records and to discuss my medical condition with the following care providers:

(Please provide the full name, address, and telephone number of all applicable providers.)

1. _____

2. _____

3. _____

The forgoing records and medical information are limited to that information which the agency needs to know to assess my reasonable accommodation request.

I understand this is the TDCJ's attempt to obtain the following medical information (as indicated):

- ☐ Confirmation that my medical condition is a disability under the *Americans with Disabilities Act*, as amended;
- ☐ The functional limitation(s) or work-related restrictions associated with the stated disability;
- ☐ Why the requested reasonable accommodation is needed;
- ☐ Clarification of medical information previously submitted to the TDCJ; or
- ☐ Recommendations regarding alternative accommodations.

The TDCJ will only request medical information that is directly related to the aforementioned.

I understand that the information that is collected and discussed is to be treated with confidentiality. However, directly relevant information may be shared with supervisors/managers or others who need to know to address work restrictions and/or accommodations, in order to make decisions, or provide advice on matters relating to my request for reasonable accommodation.

This release terminates once the accommodation request is closed.

_____ _____

Employee/Applicant Signature Date

A photocopy or facsimile of this form will serve as an original.