



## ***Americans with Disabilities Act: Employees & Job Applicants***

### **Americans with Disabilities Act: Employees & Job Applicants Policy**

*Approved by and date:*

*Board of Trustees* 08/24/2020

*Executive Leadership Team* 07/17/2020

#### **Policy:**

Kilgore College will reasonably accommodate all employees and job applicants, with known qualifying disabilities or impairments, as required by the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA), as amended by the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), where no undue hardship is imposed on the College.

#### **Procedures:**

*Approved by and date:*

*Executive Leadership Team* 10/22/2020

Full or part-time employees and job applicants are invited to advise the College of any disability-based limitations to enable the College to assist the employee and determine eligibility for reasonable accommodation(s). The College is under no obligation to provide reasonable accommodation(s) unless an individual properly identifies him/herself as a person with disability-based limitations requiring an accommodation and supplies the necessary documentation.

The College will determine, in consultation with the employee and, if necessary, his/her medical providers, what constitutes a reasonable accommodation. The College reserves the right to request additional medical examinations, evaluations, or other appropriate information at college expense, if necessary. Supervisors must contact the Human Resources Office for assistance in determining the needs of employees requesting accommodations.

Reasonable accommodation(s) will be granted, as determined by the College, unless any such accommodation(s) will cause an undue hardship for the College. In determining what constitutes a reasonable accommodation, or an undue hardship, the College's decisions will conform to definitions and guidance provided by state and federal law.

The Human Resources Office is responsible for the management, implementation and coordination of this policy. Any and all accommodations sought pursuant to this policy must be approved by the director of human resources and the employee's supervisors. All information relating to an accommodation request is considered confidential.

Processes and requirements related to this procedure are documented in Appendix A.

Processes and requirements related specifically to COVID-19 accommodations are documented

in Appendix B. Processes and requirements related specifically to service animals are documented in the Appendix C.

The College strictly prohibits discrimination and harassment against employees based on disability as defined by state and federal law. If an employee believes he or she has suffered discrimination and/or harassment based on disability, including the illegal denial of an accommodation, or retaliation for having requested an accommodation, the employee should immediately contact the Human Resources Office as provided by the Anti-Harassment & Complaint Policy.

## **Appendix A**

### **Processes and Requirements**

1. The employee notifies the Human Resources Office (HR) of his/her limitations and the need for a disability-based accommodation(s).
2. After notification, HR will provide the employee a packet of materials including an instructional cover letter, the Reasonable Accommodation Request Form, and the Reasonable Accommodation Medical Questionnaire to be completed in order to identify his/her limitations and the need for a disability-based accommodation. See Appendices D and E.
3. The completed Reasonable Accommodation Request Form and Reasonable Accommodation Medical Questionnaire must be returned to the director of human resources (director). Once the director is in possession of both forms, the director will schedule a meeting with the appropriate supervisory team. Faculty requests will be reviewed by the appropriate dean and the vice president of instruction, with the option to consult with the employee's department chair as needed. Staff requests will be reviewed by the appropriate supervisor and vice president.
4. The purpose of this meeting is to review the Reasonable Accommodation Request Form, Reasonable Accommodation Medical Questionnaire, and employee job description that outlines essential functions. The supervisory team will utilize these documents to determine what, if any, reasonable accommodations are available for the individual.
5. Upon conclusion of these deliberations, the director will prepare either the Reasonable Accommodation Approval Form or Reasonable Accommodation Denial Form. See Appendices H and I. Consultation with the College attorney will be required in most cases.
6. Once the appropriate approval or denial form is completed, the director and the appropriate supervisory team will meet with the employee requesting the accommodation. This group will cover the prepared form with the employee and secure his/her signature as verification of the communication.
7. In compliance with applicable laws and regulations, all documents pertaining to a disability request are placed in a confidential file, separate from the employee's personnel file, and may be opened only by the employee or an appropriate HR representative on a documented and approved "as needed" basis.

## **Appendix B**

### **Processes and Requirements-COVID-19 Specific**

1. The employee notifies the Human Resources Office (HR) of his/her limitations and the need for a disability-based accommodation(s).
2. After notification, HR will provide the employee a packet of materials including an instructional cover letter, the COVID-19 Work Accommodation Request Form, and the COVID-19 Healthcare Verification Form to be completed in order to identify his/her limitations and the need for a disability-based accommodation. See Appendices F and G.
3. The completed COVID-19 Work Accommodation Request Form and the COVID-19 Healthcare Verification Form must be returned to the director of human resources (director). Once the director is in possession of both forms, the director will schedule a meeting with the appropriate supervisory team. Faculty requests will be reviewed by the appropriate dean and the vice president of instruction, with the option to consult with the employee's department chair as needed. Staff requests will be reviewed by the appropriate supervisor and vice president.
4. The purpose of this meeting is to review the COVID-19 Work Accommodation Request Form, COVID-19 Healthcare Verification Form, and employee job description that outlines essential functions. The supervisory team will utilize these documents to determine what, if any, reasonable accommodations are available for the individual.
5. Upon conclusion of these deliberations, the director will prepare either the Reasonable Accommodation Approval Form or Reasonable Accommodation Denial Form. See Appendices H and I. Consultation with the College attorney will be required in most cases.
6. Once the appropriate approval or denial form is completed, the director and the appropriate supervisory team will meet with the employee requesting the accommodation. This group will cover the prepared form with the employee and secure his/her signature as verification of the communication.
7. In compliance with applicable laws and regulations, all documents pertaining to a disability request are placed in a confidential file, separate from the employee's personnel file, and may be opened only by the employee or an appropriate HR representative on a documented and approved "as needed" basis.

## **Appendix C**

### **Processes and Requirements-Service Animals**

An employee requesting use of a service animal must provide documentation that establishes the employee has an impairment that warrants the use of a service animal as defined below. Service animals are subject to local animal licensing and registration requirements and must be current on the appropriate vaccination series for the type of animal. Human Resources will notify KCPD when accommodations are granted for a service animal.

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

The College will make reasonable modifications in policies, practices, or procedures to permit the use of a miniature horse by an individual with a disability if the miniature horse has been individually trained to do work or perform tasks for the benefit of the individual with a disability. Other requirements which apply to service animals shall also apply to miniature horses. In determining whether reasonable modifications in policies, practices, or procedures can be made to allow a miniature horse into a specific facility, the College will consider:

- The type, size, and weight of the miniature horse and whether the facility can accommodate these features;
- Whether the handler has sufficient control of the miniature horse;
- Whether the miniature horse is housebroken; and
- Whether the miniature horse's presence in a specific facility compromises legitimate safety requirements that are necessary for safe operation.

Kilgore College permits service animals to accompany employees with disabilities in all areas where non-disabled employees would ordinarily have access. A person who uses a service animal is responsible for any damages caused by the animal. A service animal must be under the control of its handler. Under the ADA, service animals must be harnessed, leashed, or tethered, unless the individual's disability prevents using these devices or these devices interfere with the service animal's safe, effective performance of tasks. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

An employee cannot be asked to remove his or her service animal from College property unless: (1) the dog is out of control and the handler does not take effective action to control it or (2) the dog is not housebroken.

Other employees or students of the College with medical condition(s) that are affected by animals including, but not limited to, respiratory diseases, asthma, or severe allergies should contact the Human Resources Office if they have a concern about exposure to a service animal. The employee or student will be asked to provide medical documentation that identifies the condition(s), and will allow determination to be made as to whether an accommodation is necessary. When a person who has a medical condition that is affected by animals and an employee who uses a service animal must spend time in the same room or facility, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the facility.

## Appendix D: REASONABLE ACCOMMODATION REQUEST FORM

Employee Name: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

### A. Questions to clarify accommodation requested.

Identify the physical and/or mental impairment for which you are requesting an accommodation, including the date of the diagnosis and expected duration of the impairment.

What specific accommodation(s) are you requesting? (Please be as specific as possible.)

How long will you need the accommodation requested?

If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? Yes  No

If yes, please explain.

### B. Questions to document the reason for accommodation request.

What, if any, essential job function are you having difficulty performing?

What, if any, employment benefit are you having difficulty accessing?

What limitation is interfering with your ability to perform your job or access an employment benefit?

Have you had any accommodations in the past for this same limitation? Yes  No

If yes, what were they and how effective were they?

If you are requesting a specific accommodation, how will that accommodation assist you?

### C. Other.

Please provide any additional information that might be useful in processing your accommodation request:

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Return this form to Human Resources.

## Appendix E: REASONABLE ACCOMMODATION MEDICAL QUESTIONNAIRE

EMPLOYEE/PATIENT'S NAME: \_\_\_\_\_

EMPLOYEE/PATIENT'S WORK SCHEDULE: \_\_\_\_\_

Dear Medical Professional,

A request for a reasonable accommodation has been made by our employee, who is listed above. In order to assist with the interactive process, we are requesting you to provide feedback to the following questions based on your medical expertise. Please be as specific as possible.

### Background

An employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. **"Substantially limits" under the ADAAA has been broadened to allow** someone with an impairment to be "regarded as" having a disability, even without the perception that the impairment limits a major life activity, provided that the impairment does not have an actual or *expected* duration less than or equal to six months.

The ADAAA provides examples of "**major life activities**," including "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of a major bodily function, such as functions of the immune system, normal cell growth and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions."

**Please answer these questions to help determine disability and reasonable accommodation.**

1) Does the employee have a physical or mental impairment?

If yes, what is the impairment?

Please indicate date impairment commenced.

Please indicate if impairment comes and goes or is episodic in nature, and, if so, for what period of time do symptoms occur?

2) What limitation(s) is interfering with the employee's job performance, and how does it interfere with the employee's ability to perform the essential job function(s)?

3) Is a major life activity substantially limited by this impairment?

If yes, what activity is substantially limited?

4) What adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position?

5) The employee's typical schedule is listed on the first page. What, if any, adjustments need to be made to the employee's work schedule to enable the employee to perform the essential functions of that position?

6) How would your suggestions improve the employee's job performance?

- 7) Please review the attached job description. (If no job description is attached, please discuss the position with the employee to determine essential job duties.) Is the employee able to perform the essential job functions of this position with or without reasonable accommodation?

Yes/No

If *yes*, please continue to next question.

If *no*, how long will the employee be unable to perform these job duties?

\_\_\_\_\_ # of weeks    \_\_\_\_\_ # of months    \_\_\_\_\_ permanently

- 8) How long will the employee need the reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?

By signing below, I certify that the patient named herein is my patient and the information provided herein is based on my knowledge of his/her physical or mental impairment.

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

Type of Practice/Specialty: \_\_\_\_\_

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

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_  
Signature of Medical Professional completing form

\_\_\_\_\_  
Date

ONCE COMPLETE PLEASE RETURN THIS DOCUMENT TO YOUR PATIENT OR  
FAX IT TO THE KC HUMAN RESOURCES DEPARTMENT AT (903) 983-8609.

## Appendix F: COVID-19 Work Accommodation Request

*Employees at higher risk of severe illness from COVID-19 may request a temporary accommodation due to the potential threat of exposure to COVID-19 in the workplace. Generally, only those underlying conditions identified by the Centers for Disease Control (“CDC”) as conditions which put people at increased risk will be considered. Conditions listed by the CDC as “possibly” causing an increased risk will generally not be considered. This request must be submitted to Human Resources. In any instance where a temporary accommodation is granted, the employee must be able to perform the essential functions of their job, and the request must not impose an undue hardship on the institution or the department.*

*Based on the request and supporting documentation, Human Resources will work with the employee and/or supervisor to determine if there is an effective temporary work accommodation that will allow the employee to perform his/her job duties.*

*Any accommodation that is approved shall be approved on a temporary basis only and shall last only as long as a public health disaster shall exist, or until the College, in its discretion, determines that the accommodation will be removed. The allowance of a temporary work accommodation due to pandemic does not alter the essential functions of the employee’s job, and is not an admission or agreement that the accommodation granted is a feasible accommodation outside of this particular pandemic circumstance.*

Employee Name: \_\_\_\_\_ Employee Title: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Department: \_\_\_\_\_

Requested Start Date: \_\_\_\_\_ Requested End Date: \_\_\_\_\_

### I am requesting an accommodation because (please select one):

- I am an employee who has a disability and exposure to COVID-19 puts me at a greater health risk.** Documentation from a healthcare provider is required to verify that this accommodation request is necessary.
- I am an employee who has an underlying health condition and exposure to COVID-19 would put me at a greater health risk.** Documentation from a healthcare provider is required to verify that this accommodation request is necessary.
- I am requesting a work accommodation based on a reason that is not presented above. State reason here:

*I attest that the above information is accurate and complete to the best of my knowledge. I understand that falsification of any information provided on this document and/or any of its supporting documentation may lead to disciplinary action. Further, I understand that submission of this request, does not take the place of an approval. Human Resources will review the request and provide a response within a reasonably prompt time.*

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## Appendix G: COVID-19 Healthcare Verification Form

Employee Name: \_\_\_\_\_

*The above-mentioned individual is a Kilgore College employee who has requested workplace modifications on the basis of an underlying medical condition that puts the employee at increased risk of severe illness from the virus that causes COVID-19. In order to determine whether the employee qualifies for such modifications, we ask that you as their health care provider please provide the following information. Once completed, please return the completed form to your patient and/or Kilgore College Human Resources Office (contact information below). Please do not add conditions to this form.*

1. Please identify which of the following conditions the individual has been diagnosed with:

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 kg/m<sup>2</sup> or higher but < 40 kg/m<sup>2</sup>)
- Severe Obesity (BMI > 40 kg/m<sup>2</sup>)
- Sickle cell disease
- Smoking
- Type 2 diabetes mellitus

2. Date of last medical evaluation of this individual:

\_\_\_\_\_  
Month/Day/Year

3. Please describe the Employee's current functional limitations due to the condition indicated in Question 1 and the risks COVID-19 would have on the employee in the workplace environment.

4. If available, please attach copies of any relevant medical records to this form.

**Certifying Professional – By signing below (print/type), you are confirming that you are a qualified healthcare professional who is treating the employee named herein and you are personally providing the information above.**

Name: \_\_\_\_\_

License #: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

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

Please return this form to your patient/the employee and/or submit to  
**Kilgore College Human Resources Office**

Fax: (903) 983-8609 or Email: humanresources@kilgore.edu

If you have any questions regarding your patient's request, feel free to contact Kilgore College Human Resources Office at (903) 983-8102.

### Appendix H: REASONABLE ACCOMMODATION APPROVAL FORM

Employee Name:	Date of Approval:	
Accommodation(s) Approved:		
<b>STEPS NEEDED TO IMPLEMENT</b>		
Does equipment need to be ordered or a service purchased?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, who will do it?		
Will training be required?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, who will do the training?		
Who needs to be notified of the accommodation?		
What other steps need to be taken?		
<b>TIMEFRAMES</b>		
When will the accommodation be fully implemented?	Date:	
If maintenance is needed, when will it be done?	Date:	
Is the accommodation being provided on a trial basis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when will the trial period end?	Date:	
Comments:		

<b>SIGNATURES</b>	
Representative of KC:	Date:
Employee:	Date:

**Appendix I: REASONABLE ACCOMMODATION DENIAL FORM**

Employee Name:	Date of Denial:
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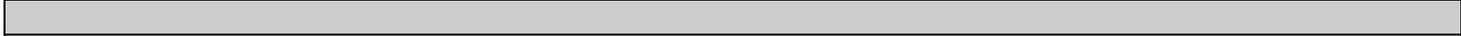
Accommodation(s) Denied:



**REASON(S) FOR DENIAL** (may check more than one box)

- Accommodation Ineffective or Unreasonable
- Accommodation Would Cause Undue Hardship
- Medical Documentation Inadequate or Missing
- Accommodation Would Require Removal of an Essential Function
- Accommodation Would Require Lowering of Performance or Production Standard
- Employee does not have a Qualifying Disability
- Other:

**DETAILED REASON(S) FOR THE DENIAL OF ACCOMMODATION**



**NEXT STEPS**

<input type="checkbox"/> Provide Additional Information <input type="checkbox"/> Meet to Discuss Other Accommodation Options <input type="checkbox"/> Explore Reassignment <input type="checkbox"/> Terminate Employment	<input type="checkbox"/> Other:
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**COMMENTS**

<b>SIGNATURES</b>	
Representative of KC:	Date:
Employee:	Date: