Instructions for Form 13661, Reasonable Accommodation Request

This form is intended to assist persons involved in the reasonable accommodation process and to memorialize important information. Completion of the form, including medical documentation if the condition is not obvious or history of, is strongly encouraged for Agency Reasonable Accommodation Services (RAS) review and record keeping purposes.

Part I – Written Reasonable Accommodation Request
To be completed by applicant for employment, employee, representative, or by an IRS official when necessary to document a reasonable accommodation request. Submitting any medical or other supporting documentation with Part I will help expedite the processing of the request for accommodation.

Part II-A – Deciding Official Documentation
To be completed by Supervisor or Deciding Official addressing management's decision. Management makes the final decision on a request for accommodation.

Part II-B – Deciding Official Documentation
To be completed by Supervisor or Deciding Official addressing management's decision. Management makes the final decision on a request for accommodation. A temporary request, condition, or accommodation should be documented on Part I and Part II with re-evaluation or ending date.

Part III-A – Medical Documentation
To be completed by Health Care Practitioner, Social Worker, or Rehabilitation Counselor.

Part III-B – Medical Documentation (Limitations Worksheet)
To be completed by Health Care Practitioner, Social Worker, or Rehabilitation Counselor. Note: Medical documentation is generally not required where the disability is obvious or known to the Agency and the nexus between the disability and the requested accommodation is apparent.

Part IV – Denial of Reasonable Accommodation Request
To be completed by Deciding Official to document the denial of reasonable accommodation.

Authorization of Representation – To be completed by representative and/or employee for authorized representation for request.

Privacy Act Statement

Collection of the requested information is authorized by Section 501 of the Rehabilitation Act, 29 U.S.C. § 791.The information you furnish will be used for the purpose of facilitating your request. Additionally, the information may be used to disclose information to: appropriate Federal, state or local agencies when relevant to civil, criminal or regulatory investigations or prosecutions when necessary to adjudicate a claim for benefits; a Federal agency in connection with a decision in hiring, retention or the granting of a security clearance. It may also be used in an administrative or judicial proceeding affecting an employee's personnel rights and in any criminal prosecutions for willfully making false or fraudulent statements in violation of U.S.C. § 1001. Additional uses may include disclosure to the Department of Justice for the purpose of litigating any civil, administrative, or judicial proceeding where the United States, the IRS, or its employees (in their official capacities or where the government has decided to represent them) are parties. It may also be used in response to subpoena from a third party provided that (1) IRS is a party in interest, (2) the records are relevant and necessary to the litigation, and (3) not otherwise privileged. This information may be provided to professional associations, such as state bar disciplinary authorities, for use in connection with their administration of standards of conduct. Further, it may be disclosed to contractors when necessary to perform work associated with reasonable accommodation and to those Federal agencies that oversee property and procurement matters. Furnishing the requested information is required to establish that you have a covered disability, the functional limitations of your disability, and the need for reasonable accommodation. Failure to fully complete the form or refusal to provide the requested documentation may lead to a breakdown in the reasonable accommodation process and could result in a determination that you are not entitled to reasonable accommodation.

Nondisclosure of GINA Protected Information

The Genetic Information and Nondiscrimination Act of 2008 *(GINA)* prohibits employers and other entities covered by GINA Title II from requesting, requiring, or purchasing genetic information of employees or their family members, except as specifically allowed by this law. GINA has specific exceptions for requests under the Family and Medical Leave Act and the Rehabilitation Act, as explained below. To comply with GINA, we are asking that you not provide any genetic information when responding to this request for medical information, unless the information is allowable as explained below.

“Genetic information”, as defined by GINA, includes information concerning the manifestation of disease/disorder in family members *(“family medical history”)*, information about 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. **Document 12986 - Nondisclosure of GINA Protected Information** *(Provided for your information)*.

Family and Medical Leave Act (FMLA)

The general prohibition against requesting or requiring genetic information does not apply where an employer requests medical information of an employee who invokes the FMLA to attend to the employee's own serious health condition or where an employee complies with the employer's return to work certification requirements. See 29 CFR 1635.8*(b)(1)(i)(D)(2)*. An employer does not violate GINA by asking an employee seeking FMLA leave to care for a seriously ill family member to provide family medical history to comply with the certification provisions of the FMLA. See 29 CFR 1635.8*(b)(3)*.

Further, GINA permits disclosure of relevant genetic information consistent with the requirements of the FMLA to persons with a need to know the information because of responsibilities relating to the handling of FMLA requests. See 29 CFR 1635.9*(b)(5)*.

Rehabilitation Act

The general prohibition against requesting or requiring genetic information does not apply where an employer requests documentation to support a request for reasonable accommodation as long as the request for documentation is lawful. Such a request is lawful only where the disability and/or the need for accommodation is not obvious; the documentation required contains no more information than what is sufficient to establish that an individual has a disability and needs reasonable accommodation; and the documentation relates only to the impairment that the individual claims to be a disability that requires reasonable accommodation. See 29 CFR 1635.8*(b)(1)(i)(D)(1)*; see also 29 CFR 1635.8*(b)(1)(i)(B)*.

Reasonable Accommodation Request

Part I. Written Reasonable Accommodation Request

To be completed by applicant, employee, or IRS official

1. Applicant/Employee information		2. Occupational			3. Operating Division/Function
Last name	First name	SEID	Series	Grade	

4. Contact information

Office telephone number	FAX number	Cubicle, floor, or building code	Tour of Duty/Shift *(work hours)*
Post of Duty *(POD)* City		State	ZIP code
E-mail address		Preferred method/time to contact (cell phone or email, hours)	

5. Mailing address *(where you receive official correspondence)*

Address 1 *(work)*		Address 2 *(home)*		
Room #	Mail Stop	City	State	ZIP code

6. Manager's contact information

Manager's name	SEID	Telephone number	E-mail address
Post of Duty *(POD)* City		State	ZIP code

7. Medical condition *(Describe your medical condition requiring accommodation.)*

8. Job functions affected *(Describe how your medical condition limits your ability to perform your current duties, participate in the application process, or access a benefit of employment. Copy of position description or clarify essential job functions impacted.)*

9. Accommodation requested *(Based on your disability or medical condition and job functions affected, what accommodations would help you to perform effectively.)*

10. List alternative accommodation options to consider

I affirm that all statements made above are true to the best of my knowledge and belief.

Signature of Applicant/Employee	Date signed

Authorization of Representation Name / Contact Information *(attach release form to package)*

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Reasonable Accommodation Request

Part II-A. Supervisor/Deciding Official Documentation

To be completed by Supervisor/Deciding Official

1. Name of Applicant/Employee	RA case number

2. Supervisor/Deciding Official

Last name	First name	Title	SEID

Post of Duty *(POD)* City	State	ZIP code

Telephone number *(Including Area Code)*	E-mail address

3. Is the employee's/applicant's condition obvious or otherwise known to management ☐ Yes ☐ No

4. What duties or functions of the job are limited by the applicant/employee's medical condition. *(Refer to the Position Description, Critical Job Elements (CJE), applicant requirements, or other relevant documentation).*

5. Does this limitation affect an essential function of the job or participation in the application process *(See RAC if essential job function worksheet is needed). Explain answer* ☐ Yes ☐ No

6. Will the requested accommodation allow the applicant/employee to successfully perform the essential job functions or participate in the application process. Explain answer ☐ Yes ☐ No ☐ Not sure

7. Describe any interim accommodation efforts, alternative accommodation recommendations or previously approved accommodations

8. Further medical information/review: Does management need additional medical information ☐ Yes ☐ No

9. Potential review through Federal Occupational Health (FOH) ☐ Yes ☐ No

If either additional medical information or review by FOH is necessary. Explain the need *(Additional medical information should not be sought where the condition is obvious or known and the connection to the requested accommodation is apparent)*

I affirm all statements made above are true to the best of my knowledge and belief.

Signature of Supervisor/Deciding Official	Date signed

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Reasonable Accommodation Request

Part II-B. Action by Deciding Official

To Be Completed After Review of Accommodation Request

☐ Request approved ☐ Alternative accommodation approved ☐ Accommodation denied

If an alternative accommodation approved, describe accommodation approved

If the condition and/or accommodation is temporary, document specifics with date to re-evaluate.	Review date

Signature of Deciding Official	Date signed

Deciding Official

Last name	First name	Title	SEID

Telephone number *(Including Area Code)*	E-mail address

Post of Duty *(POD)* City	State	ZIP code

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Reasonable Accommodation Request

Part III-A. Medical Documentation

To be completed by a Health Care Practitioner, Social Worker, or Rehabilitation Counselor

Name of Applicant/Employee

Instructions

We have been requested to consider a reasonable accommodation for the individual named above. An accommodation is a modification made to a job and/or the work environment that enables a qualified employee/applicant with a disability to successfully perform the essential duties or functions of the position. We request that you provide medical information which reflects:

- the individual has one or more physical or mental impairment that substantially limit(s) one or more of his/her major life activities (e.g., walking, speaking, breathing, hearing, seeing, thinking, sitting, standing, reaching, interacting with others, learning, performing manual tasks, caring for oneself, concentrating, lifting, working, sleeping),
- a relationship or nexus between the medical condition(s) and the recommended accommodation(s).

Medical Documentation; provide a copy of employee position or job description

1. Have you made a diagnosis that relates to this reasonable accommodation request? State the diagnosis

2. Describe what limitations result from this condition, address any workplace safety concerns or impact to perform essential job duties that may result from the condition. *(Complete Part III-B)*

3. What is the anticipated duration of this medical condition

4. Recommended options or alternatives for accommodation efforts

Certification

Name of Health Care Practitioner, Social Worker, Rehabilitation Counselor	Telephone number	Best method and time to contact

I understand an IRS medical consultant may contact me for additional information.

Signature	Date signed

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Reasonable Accommodation Request

Part III-B. Medical Documentation

To be completed by a Health Care Practitioner, Social Worker, or Rehabilitation Counselor

Name of Applicant/Employee

Instructions

1. The following table indicates the major life activity that is affected by the applicant/employee's medical condition. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty.
2. Indicate only the major activity affected by the applicant / employee's medical condition by circling or checking the appropriate block. Indicate the specific limitation of the applicant / employee resulting from their condition. Quantify their limitation in order for the agency to determine appropriate workplace accommodations (1-2 hours, 100 feet, 75% of day, or other notation).

Activity	Extent of Limitation	Detailed Explanation/Recommendation
Sensory ☐ Seeing/Vision ☐ Hearing	☐ Limited to:	
Breathing/Respiratory	☐ Limited to:	
Speaking	☐ Limited to:	
Basic Mobility ☐ Walking ☐ Climbing stairs ☐ Sitting ☐ Standing	☐ Limited to: _____ Hours per day _____ Distance _____ % of day	
Secondary Mobility ☐ Squatting/kneeling ☐ Twisting (neck/waist) ☐ Bending/stooping ☐ Reaching above shoulder	☐ Limited to: _____ Hours per day	
Physical Exertion ☐ Pushing/pulling ☐ Lifting/Carrying	☐ Limited to: _____ Number of pounds	
Fine Motor Skills ☐ Keyboard use ☐ Repetitive use of hands ☐ Grasping ☐ Fine finger motions	☐ Limited to: _____ Hours per day	
Cognitive ☐ Thinking ☐ Learning ☐ Comprehending ☐ Concentrating	☐ Limited to:	
Caring for self ☐ Self-medication/checks ☐ Dressing	☐ Limited to:	
Mental/emotional	☐ Limited to:	
Sleeping	☐ Limited to:	
Other/Bodily Functions	☐ Limited to:	

Certification

Name of Health Care Practitioner, Social Worker, Rehabilitation Counselor	Signature	Date signed

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Reasonable Accommodation Request

Part IV. Denial of Reasonable Accommodation Request

To be completed by Deciding Official

Name of Applicant/Employee	RA case number

Accommodation requested	Accommodation offered to Applicant/Employee

1. Reason for denial *(check all that apply)*

- [ ] Accommodation Ineffective/Inappropriate
- [ ] Accommodation Would Cause Undue Hardship
- [ ] Employee did not accept an alternative accommodation offered
- [ ] Medical Documentation Inadequate
- [ ] Accommodation Would Require Removal of Essential Function
- [ ] Accommodation Would Require Lowering of Performance or Production Standard
- [ ] Other (Identify) ______________________

2. Detailed reason(s) for the denial of reasonable accommodation *(e.g., why accommodation is ineffective or causes undue hardship)*

3. If the individual did not accept an alternative accommodation, explain how the alternative accommodation addresses the limitation, and why you believe the chosen accommodation would be effective

4. Appeal Process:

- Refer to IRM 1.20.2.
- A request to the Deciding Official for reconsideration based on new medical documentation or other previously unavailable information may be made within 15 business days of receipt of this denial.
- An appeal to the Business Unit Chief/Commissioner may be initiated within 15 business days of the denial of accommodation or within 15 business days of a denial of a request for reconsideration by the Deciding Official, unless an alternative effective accommodation has been offered.
- To initiate an EEO complaint contact an EEO counselor within the IRS within 45 calendar days of an allegedly discriminatory action/event.
- Bargaining Unit employees may file a grievance in accordance with the terms of the collective bargaining agreement.
- An appeal to the Merit Systems Protection Board may be filed within 30 calendar days of an adverse action as defined in 5 C.F.R. 1201.3.

Signature of Deciding Official *(If denied)*	Date signed

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