Arkansas Department of Military
Cabinet Secretary - Major General Jonathan M. Stubbs,
The Adjutant General

Policy Title: Americans with Disabilities Act Policy (ADA)

Policy Number: 13

Authority: Ark. Code Ann. § 12-61-106; 42 U.S.C. § 12101 *et seq*.

Effective Date: June 1, 2023

I. PURPOSE:

The purpose of this policy is to ensure people with disabilities have equal opportunity with the Department of the Military (DOTM).

II. POLICY:

The Department of the Military does not discriminate on the basis of disability in its hiring or employment practices and complies with all regulations promulgated by the U.S. Equal Employment Opportunity Commission under Title I of the ADA.

Individuals with covered disabilities under the Americans with Disabilities Act (“ADA”), 42 U.S.C. § 12101 *et seq*. may seek reasonable accommodations to help execute their employment with DOTM. The ADA defines a covered disability as "a physical or mental impairment that substantially limits a major life activity". Examples of "major life activities" include, but are not limited to, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working" as well as the operation of several specified "major bodily functions".

To begin the interactive process to determine what, if any, reasonable accommodation is appropriate, the employee should complete the “Reasonable Accommodation Request Form for Employees” (Attachment A) and “Release of Medical/Treatment Records Authorization for Use and Disclosure of Protected health Information” (Attachment B) and submit to his or her supervisor or Human Resources. Within 10 business days of receipt of the employee’s request for accommodation, Human Resources will, with the aid of the employee when needed, request and/or gather information about the employee’s medical condition, including how the requested accommodation would enable the employee to better perform his or her job.

Within 10 business days of gathering the necessary information, Human Resources shall meet with the employee, either in person or via phone, to discuss possible accommodations or what other information it needs to accommodate the employee.

Within five (5) business days of meeting with the employee, Human Resources shall notify the employee in writing of its decision regarding an accommodation, and if applicable, the specifics of the accommodation. If Human Resources believes an accommodation is not warranted, it shall provide the employee a written explanation of its denial. Employees who wish to appeal a denial of accommodation should follow the grievance procedure set forth below.

The employee has 5 business days from the date of Human Resources' notification of accommodation to accept the accommodation or propose an alternative. If an alternative is proposed, Human Resources has three (3) business days to respond to the proposal. This process will continue with each side having 3 business days to respond until the interactive process is complete and a final decision from Human Resources is issued. Either side may request an extension during this process if needed to gather additional medical documentation or other needed information to facilitate the accommodation request.

DOTM is not required to provide the employee for the exact accommodation requested. DOTM is only required to provide a reasonable accommodation to the employee's disability. DOTM is not required to provide an accommodation that would subject it to undue hardship or fundamentally alter the nature of its programs. In all accommodations, the employee must be able to fulfill his or her basic job functions.

III. GRIEVANCE PROCEDURE UNDER THE ADA

Employees wishing to file an internal complaint regarding disability discrimination and/or denial of accommodation should file a written complaint containing specific facts about the alleged discrimination, such as name, date, location, and description of the problem.

The complaint should be submitted by the grievant and/or his/her designee as soon as possible but no later than 5 business days after the alleged violation to:

EEO/ADA Coordinator
Department of the Military
Building 4201, Box 28
Camp Joseph T. Robinson
North Little Rock, AR 72199-9600

Within 15 calendar days after receipt of the complaint, the ADA Coordinator, or his/her designee will meet with the complainant to discuss the complaint and the possible resolutions. Within 15 calendar days of the meeting, the ADA Coordinator, or his/her designee will respond in writing. The response will explain the position of the DOTM and offer options for substantive resolution of the complaint.

If the response by the ADA Coordinator or her designee does not satisfactorily resolve

the issue, the complainant and/or his/her designee may appeal the decision within 15 calendar days after receipt of the response to the DOTM's Chief of Staff.

Within 15 calendar days after receipt of the appeal, the Chief of Staff, or his or her designee, will meet with the complainant to discuss the complaint and possible resolutions. Within 15 calendar days after the meeting, the Chief of Staff or Chief of Staff designee will respond in writing in a format accessible to the complainant, with a final resolution of the complaint.

All written complaints received by the ADA Coordinator, or his/her designee, appeals to Department of the Military, and responses from the office will be retained by the Department of the Military for at least three years.

Reasonable Accommodation Request Form for Employees

All information regarding an individual's medical condition and the reasonable accommodation request is confidential and only disclosed to persons on a need to know basis. Any and all documents related to this request are kept confidential and will be maintained and used in accordance with applicable state and federal law.

Instructions: Individuals who are employed at the Arkansas Department of Military and are requesting a reasonable accommodation(s) under the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act, relevant state law, and accompanying state and federal regulations, are encouraged to complete this form in its entirety.

In order to explore possible coverage and reasonable accommodations, information is required regarding your medical condition, essential job functions, applicable functional limitations and your requested accommodation(s). It is often necessary for Human Resources staff of the Arkansas Department of Military to discuss your medical condition and the documentation you submit to our office with providers such as licensed physicians, psychologists, or other qualified professionals. If you need help in completing this form, someone else may complete it on your behalf, or you may contact the ADA Coordinator for assistance.

Upon completion, please forward this form, along with information from your qualified healthcare professional documenting your disability and the need for reasonable accommodation to the ADA Coordinator.

You may be asked to submit a list of specific questions to your health care or vocational professional. Please be sure you sign this form.

If you have questions, please call the Arkansas Department of Military Human Resources Office at 501-212-5380.

☐ Employee ☐ Other(specify) _____

Name: _____
First Middle Last

Job Title: _____

Department: _____

Work Address: _____
City State ZIP Code

Work Telephone Number: S _____

Work Email: _____

Home Address: _____
City State ZIP Code

Home Telephone Number: _____

Home Email: _____

Preferred method of contact: ☐ Home Phone ☐ Home Email ☐ Work Phone ☐ Work Email

How long have you worked in current position? _____

Administrator/Supervisor's Name:

_____
First Middle Last

Job Title: _____

Division: _____

Work Telephone Number: _____

Work Email: _____

Medical Information

Please identify the medical condition(s) for which you are requesting an accommodation.

Please provide the name and contact information for the health care professional who diagnosed the medical condition(s) listed above. Please include the date of diagnosis.

Reasonable Accommodation Request Form for Employees

Job and Accommodation Information

Please explain how your medical condition(s) listed above affects your ability to perform the essential functions of your position. If you are a new employee, state the anticipated difficulties you foresee in completing your job duties. Be as specific regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

Please provide your recommendations for a reasonable accommodation(s) and any information you may have about any associated costs (attach supporting documentation).

Please describe any accommodations or assistive technologies you currently use.

Please add any comments you feel may be helpful in consideration of your request.

Acknowledgement

I understand that it will be my responsibility to complete submit a list of questions to my medical professional, if required by the Arkansas Department of Military, and provide it to the Arkansas Department of Military ADA Coordinator for my request to be evaluated. I further understand that the Arkansas Department of Military ADA Coordinator will evaluate and respond to me based upon the information that I provide.

Employee Signature _____ Date _____

☐ Please check here if additional information is attached to this request.

Release of Medical/Treatment Records Authorization for Use and Disclosure of Protected Health Information

Heath Care Provider Information

I Authorize:

Attending Provider Name: _____

Provider Specialty: _____

Mailing Address: _____

City, State, Zip: _____

Phone: Number: _____

To Release Information to:

Americans with Disabilities Coordinator
Arkansas Department of Military
Building 4201
Camp Joseph T. Robinson
North Little Rock, AR 72199-9600

The following about me can be released and discussed:

I hereby authorize the ADA Coordinator for the Arkansas Department of Military to communicate directly with the health care provider listed on this form in order to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation. All Clinical records, including any records transferred from other medical/treatment facilities, doctor/therapist notes, and progress notes related to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation.

Purpose of this authorization: I have requested an accommodation from the Arkansas Department of Military under The Americans with Disabilities Act (ADA) of 1990.

∗ A COPY OF THIS FORM IS AS EFFECTIVE AS THE ORIGINAL. ∗

_____ Employee's Printed Name

_____ Employee's Phone Number

_____ Employee's Signature

_____ Date Signed

CONFIDENTIALITY NOTICE: Medical-related information shall be kept confidential and maintained separate from other personnel records. However, supervisors and managers may be advised of information necessary to the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information.