Please provide complete information in each field.

Employee Information

Employee Name: First | Middle | Last

Employee ID: **Birth Date:**

Home Address: Address

City | State | ZIP

Home Phone:

Work Address: Building Address | Street Address

City | State | ZIP

Work Phone:

E-mail Address:

Position Title:

Department:

Appointment Type: AFSCME ☐ Teamster ☐ Civil Service ☐ P & A ☐ Faculty ☐

Employment Status: FT ☐ PT ☐ **Hours/week:**

Supervisor:

Supervisor Title: **Phone**

This form may be filled in, printed, and the paper copy signed and hand delivered or faxed to the contact information below:

Sarah Yang
255 Darland Administration Building
1049 University Dr.
Duluth, MN 55812
Fax: (218)726-7505

Disability Services
Office for **Equity and Diversity**
University of Minnesota
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Disability Services
Registration Agreement

1. I understand that I am registering for services from Disability Services at the University of Minnesota and that I may be eligible for services such as information, referral, reasonable accommodations and/or other individualized services that may be needed for access to employment, courses, activities, programs, services, or facilities.

    - I understand that the University needs information about health or disability impacts to provide services and to conduct reporting and research functions. These data are classified by condition and do not include personally identifiable information.

    - I understand that as a user of Disability Services, I am responsible for reviewing the rights and responsibilities pertaining to disability access (Students only, see Disability Services Handbook).

    - I understand that Disability Services employs an interactive process to determine eligibility for services and potential accommodations, and foremost in this process is a thorough self-report of personal impact. However, I also understand that services or accommodations are best identified when Disability Services is able to review current impact information described by a service provider who is qualified to describe or diagnose a disability or significant medical condition.

2. I understand that if I request Disability Services to facilitate accommodations on my behalf, they may need to consult with other University personnel and may share information about the impacts of my condition as necessary.

3. I have been given a copy of the Disability Services Handbook, and agree that I am responsible for understanding and following its provisions (Students only).

Name (print) _____

Signature _____ **Date** _____

Disability Services _____ **Date** _____

Disability Services
Office for **Equity and Diversity**
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Rights & Responsibilities of People with Disabilities Regarding Access to the University of Minnesota

Rights to:

- an equitable opportunity to participate in and benefit from employment, courses, programs, services and activities offered through the University;
- an equitable opportunity to work and to learn, and to receive reasonable accommodations, academic adjustments and/or auxiliary aids and services;
- appropriate confidentiality of all information regarding their disability/health condition and to choose to whom, outside of the University, information about their disability will be disclosed, except as required/permitted by law;
- information reasonably available in accessible formats.

Responsibilities to:

- meet qualifications and maintain essential institutional standards for employment, courses, services and activities;
- self-identify as an individual with a disability/health condition in a timely manner when an accommodation is needed, and seek information, counsel and assistance as necessary;
- provide documentation from an appropriate professional which describes how the health condition or disability impacts participation in employment, courses, programs, services or activities;
- abide by the University of Minnesota Code of Conduct (available at http://regents.umn.edu/policies/index/academic/Code_of_Conduct.pdf) and Student Conduct Code (available at http://regents.umn.edu/sites/default/files/policies/Student_Conduct_Code.pdf).

Rights & Responsibilities of the University of Minnesota Regarding Disability Access

Rights to:

- evaluate faculty, staff and students, and identify and establish essential functions, abilities, skills and knowledge for their employment, courses, programs, services and activities;
- request and receive, through Disability Services, current documentation that supports requests for reasonable accommodations, academic adjustments and/or auxiliary services;
- deny a request for reasonable accommodations, academic adjustments and/or auxiliary services if the documentation demonstrates that they are not warranted or if the individual fails to provide appropriate documentation;
- select among equally effective reasonable accommodations, adjustments and/or auxiliary services;
- refuse an unreasonable accommodation, adjustment and/or auxiliary services or one that imposes an undue hardship or fundamental alteration on a program or activity of the University.

Responsibilities to:

- provide information in accessible formats to faculty, staff, students and guests with disabilities upon request;
- ensure that employment, courses, programs, services and activities, when viewed in their entirety, are available and usable as broadly as possible;
- provide or arrange reasonable accommodations, academic adjustments and/or auxiliary services for faculty, staff, students and guests with disabilities in employment, courses, programs, services, facilities and activities;
- maintain appropriate confidentiality of records and communication, except as permitted/required by law.

Grievance Process

If you would like to address concerns about DS services, please follow the process outlined below:

1. In most situations, concerns should first be discussed between the individual and the DS staff.
2. If concerns persist, they should be brought to the Associate Director in Disability Services.
3. If concerns continue to persist, they should then be brought to the Director of Disability Services.
4. If you believe that you have been discriminated against because of your disability, consult with the University of Minnesota Office of Equal Opportunity and Affirmative Action at 612-624-9547 and https://diversity.umn.edu/eoaa/

Disability Services
Confidentiality and Release of Information Policies

Disability Services collects information to assist in determining reasonable accommodations for students and employees of the University of Minnesota and is committed to following legal guidance in maintaining and protecting the confidentiality of this information. The information may include biographical history, health or disability information, assessment data, grades, performance reviews, and case notes. The intent of this document is to inform you of Disability Services' policies with regard to confidentiality and the release of this information. These policies incorporate relevant state and federal regulations, guidelines established by relevant professional associations, and the University Board of Regents' policies on managing personal information.

1. Only Disability Services staff has automatic access to files. Any information gathered to determine the existence of a disability and reasonable accommodations will be considered highly confidential and will be shared with others within the institution on a need-to-know basis only. For example, University faculty and staff do not need access to diagnostic information regarding an individual's health or disability condition. However, they may need to know an individual's functional limitations and what accommodations are necessary/appropriate to meet the individual's disability/health-related needs. All health/disability-related information will be sent to and filed with Disability Services in order to protect confidentiality by limiting access to that information.
2. Information in files will not be released except in accordance with federal and state law, which require release in circumstances in which an individual
    - states they intend to harm themselves or another person(s);
    - reports or describes any physical abuse, neglect, or sexual abuse of children or vulnerable adults within the last three years (this includes the occurrence of abuse or neglect to the individual if they were under age 18 at the time of the abuse);
    - reports the use of an illegal drug for non-medical purpose during pregnancy; or
    - reports or describes sexual exploitation by counseling or health-care professionals.
3. An individual's file may be required to be released in response to a court order or subpoena.
4. An individual may give written authorization for the release of information when they wish to share it with others. Before giving such authorization, the individual should satisfy themselves that the information is necessary to share, that they understand the contents of the information being released, and that providing this information is in their best interest.
5. Disability Services may charge a reasonable fee for costs incurred related to release of information.
6. Disability Services will retain a copy of all information provided. If an individual wishes to have a record expunged, they must make a written request to the Director, who will make a decision whether it is necessary for Disability Services to retain the record.
7. Disability Services may communicate or share health/disability information on a need-to-know basis as necessary to provide reasonable accommodations.

I agree that I have reviewed, understand, and agree to the above information.

Signature _____ **Date** _____

If under 18 years of age,
Signature of Parent/Guardian _____ **Date** _____

Release of Information
to Disability Services

I authorize (person's name) _____

From: (site and fax #) _____

To release to and/or discuss with Disability Services the following information:

- Diagnosis of medical, mental health, or learning condition(s) that may be disabling
- How the condition(s) may affect me in an academic or employment setting
- (Optional) Recommendations for academic or employment accommodations

Send information to: _____ _____ _____
(Name) (Telephone) (Fax)

Disability Services, McNamara Alumni Center, Suite 170/180
200 Oak St. SE, Minneapolis, MN 55455

Purpose for which information will be used:

To assist the University of Minnesota in determining whether I have a disability as defined by the ADA, and what reasonable accommodations may be appropriate.

My Identification:

Name _____ _____ _____
(First) (Middle) (Last)

Address _____
(Number & Street)

_____ _____ _____
(City) (State) (Zip)

Date of Birth _____ Telephone _____

Dates of Services/Treatment (starting) _____ (to) _____

- I accept responsibility for any use made of the information as a result of this authorization.
- I understand that this authorization has no expiration date and that I may revoke it in a written request (or email) to DS at any time. I also understand the revocation will not apply to information released under this release prior to Disability Services receiving any revocation.
- I understand that my health care provider's treatment is not conditional on signing this authorization.
- I understand that if I do not authorize Disability Services to obtain the information requested in this release, Disability Services may be unable to provide the services I am requesting.
- I understand that I am entitled to a copy of this authorization.
- I have been informed and understand that the information released by my provider to DS in accordance with this authorizationmay be redisclosed by DS and no longer protected by HIPPA. I am also aware that any information disclosed to Disability Services is subject to other state and federal privacy laws.
- This authorization encompasses all records pertaining to my condition, including third party records created by other individuals or organizations.

Signature _____ **Date** _____

If under 18 years of age,
Signature of Parent/Guardian _____ **Date** _____

Disability Services
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Release of Information
from Disability Services

I authorize Disability Services to release and discuss information as specified below.

1. **Information to be discussed/released**:
   - ☐ health/disability information
   - ☐ health/disability related impacts in an academic or employment setting
   - ☐ reasonable accommodations
   - ☐ other _____

2. **Person to release and/or discuss with:**

   _____ _____
   Name Relationship to you

   _____
   Address

   _____
   Contact Information (email, phone)

3. **The purpose for which the information will be used:**
   - ☐ better understand accommodation needs
   - ☐ facilitate timely communication
   - ☐ other _____

4. **My Identification:** *(Please print)* **Date of Birth** _____

   _____ _____ _____ _____
   Name (Last) (First) (Middle)

   _____
   Address

   _____ _____ _____
   City State Zip

   U of M ID # _____ Telephone _____

5. ***If under 18,*** **I authorize Disability Services to discuss my overall academic status as it relates to my disability with one of my parents or guardians.**

I accept responsibility for any use that may be made of the information as a result of this release. I understand that there is no expiration date for this authorization to release information, and that I may revoke it in writing at any time, except to the extent that this authorization has already been relied upon.

Signature _____ **Date** _____

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Release of Information
from Disability Services to Union Representatives

I authorize Disability Services/UReturn to release and discuss information as specified below with representatives of my Union.

1. **Information to be discussed/released**:
   - ☐ health/disability related impacts in the employment setting
   - ☐ reasonable accommodations

2. **Person to release and/or discuss with:**

Name _____ Union _____

3. **My Identification:** *(Please print)* **Date of Birth** _____

Name _____ (Last) _____ (First) _____ (Middle)

Address _____

City _____ State _____ Zip _____

U of M ID # _____ Telephone _____

I understand that without this authorization, Disability Services/UReturn will not be able to provide any information regarding my functional limitations, necessary accommodations or related employment matters to any bargaining unit representative.

I accept responsibility for any use that may be made of the information as a result of this release. **I understand that there is no expiration date for this authorization to release information, and that I may revoke it in writing at any time.**

Signature _____ **Date** _____

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