

AMERICANS WITH DISABILITIES ACT (ADA) INTAKE QUESTIONNAIRE

(THIS FORM MUST ACCOMPANY A GENERAL INTAKE QUESTIONNAIRE)

FAIR EMPLOYMENT PROGRAM

CHEYENNE OFFICE:

Labor Standards
1510 E. Pershing Blvd.
West Wing, Room 150
Cheyenne, WY 82002
(307) 777-7261 FAX (307) 777-5633

CASPER OFFICE:

Labor Standards
851 Werner Court
Suite 121
Casper, WY 82601
(307) 235-3679 FAX (307) 235-3688

DATE: _____

Please answer the following questions telling us briefly why you believe you have been discriminated against by your employer or potential employer. After you complete this questionnaire, submit the **signed** document to THE NEAREST LOCAL OFFICE at the addresses noted above.

UNDER STATE LAW, YOU HAVE **SIX (6) MONTHS** FROM THE LAST DISCRIMINATORY ACT IN WHICH TO FILE A VERIFIED COMPLAINT WITH OUR OFFICE, AND **300 DAYS** FROM THE LAST DISCRIMINATORY ACT IN WHICH TO FILE UNDER FEDERAL LAW. IF YOU HAVE ALREADY FILED WITH A STATE AGENCY, OR IF YOU ARE COMPLAINING ABOUT SOMETHING WHICH HAPPENED TO YOU OVER 300 DAYS AGO, STOP AND CONTACT A COMPLIANCE OFFICER BEFORE PROCEEDING FURTHER WITH THIS QUESTIONNAIRE.

NAME: _____
(First) (Middle Initial) (Last)

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

TELEPHONE NUMBER (Include area code): WORK _____ HOME _____

I prefer to be contacted at WORK HOME Days _____ Time _____

YOUR SOCIAL SECURITY # _____ YOUR SEX MALE FEMALE

YOUR DATE OF BIRTH _____ YOUR AGE _____

MAJOR LIFE ACTIVITY AFFECTED:

- | | | | |
|---------------------------------------|--------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speaking | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Learning | <input type="checkbox"/> Caring/Self | <input type="checkbox"/> Working |
| <input type="checkbox"/> Manual Tasks | <input type="checkbox"/> Other _____ | | |

If you have been medically diagnosed as having a permanent or long-term physical or mental disability, will you provide a copy of your doctor's diagnosis or sign a release so that the Wyoming Fair Employment Program can obtain a copy? Yes No

What is your actual medical diagnosis by your physician (physical or mental?)

Physician's Name _____

Address _____

Telephone No. (Include Area Code) _____

Is the employer aware of your disability? [] Yes [] No

Does the employer have a record of your disability? [] Yes [] No

Type of record: _____

Date(s) of record: _____

How does the employer know about your disability? _____

What is/was your actual position title, or potential position? _____

List Job Qualifications (Attach copy of job description if available):

Were you qualified for this position? [] Yes [] No qualifications necessary for the job.

1. Education _____

2. Experience _____

3. Skills _____

4. Other _____

Essential functions: (What are/were your actual job duties or most important aspects of performing your job? Include estimated percentages of time for each function/aspect required.)

Are/were you able to perform the essential functions of your job **WITH** reasonable accommodation?

Yes No

Are/were you able to perform the essential functions of your job **WITHOUT** reasonable accommodation?

Yes No

Did you perform the essential functions of your job satisfactorily?

Yes No

Did you have regularly scheduled performance evaluations? Yes No If so, how were you rated on your last two performance evaluations? (*Rating and the date rated, if known.*) If necessary, will you provide copies to the Wyoming Fair Employment Program?

Did you ever request to be accommodated by the employer so that you could perform your job? Yes No
If so, who did you talk to and when?

Name, Title and Date _____

What did you request? _____

Did the employer attempt to provide accommodation? Yes No When?

Was an accommodation:

offered considered effective accepted rejected alternative proposed

any consultation with the employer Yes No

When (date): _____

Person(s) present: _____

If you do need reasonable accommodation to perform the essential functions of your job, what type of accommodation is required?

Restructure Job Reassign Duties Modify Schedule Adjust Leave Policy

Equipment Modify Policies Interpreters Personal Assistant

Reassignment Temporary Light Duty _____

Did you get a notice of discharge from the employer? Yes No If so, submit a copy of the notice. If not, state the reason given for your discharge by the employer.

Did the employer hire someone to fill your position? Yes No If so, do you know this person's name?
(Provide name) _____

MEDICAL QUESTIONS-- Were you asked questions about your disability or about your use of sick leave or Workers' Compensation benefits? *(Check appropriate block)*

- * On an application form Yes No
- * Before a conditional job offer was made Yes No
- * At any time during the employment relationship Yes No

MEDICAL EXAMINATION *(Check appropriate block)*

- * Were you required to take a medical examination before a job offer was made? Yes No
- * If not, did you have to take a medical exam at any time that other employees or applicants were not required to take? Yes No
- * Was any required medical exam job-related? Yes No

Did the employer provide assurances that a medical exam would be confidential? Yes No

Did the employer indicate that your handicap was a threat to the safety of other workers? Yes No

Do you believe that you were subject to handicap discrimination through a contract? Yes No If so, provide a copy of the contract.

Do you believe you were subject to discrimination on the basis of your relationship or association with an Individual with a Disability? Yes No

Do you believe that you were discriminated against because the employer perceived or perceives that you have a handicap, even though you may or may not in fact have a handicap? Yes No If yes, please explain further:

Signature of Potential Charging Party:

Date Signed:

BE ADVISED THE SUBMITTING OF THIS QUESTIONNAIRE IS NOT A FORMAL COMPLAINT. YOUR CHARGE WILL NOT BE CONSIDERED LEGALLY FILED UNTIL IT IS SIGNED AND NOTARIZED, STAMPED IN BY THIS OFFICE, GIVEN WFEP AND EEOC NUMBERS, AND IS DETERMINED TO BE MINIMALLY SUFFICIENT IN DATA.