***AMERICANS WITH DISABILITIES ACT (ADA) INTAKE QUESTIONNAIRE***

*(THIS FORM MUST ACCOMPANY A GENERAL INTAKE QUESTIONNAIRE)*

**FAIR EMPLOYMENT PROGRAM**


**CHEYENNE OFFICE:**
Labor Standards
5221 Yellowstone Road
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:

[ ] Seeing [ ] Hearing [ ] Speaking [ ] Walking
[ ] Breathing [ ] Learning [ ] Caring/Self [ ] Working
[ ] Manual Tasks [ ] 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.