

PA Human Relations Commission Use Only

Revised 08.05

Docket No. _____

EEOC No. _____

Social Security No. _____

PHRC can investigate complaints of discrimination in: (1) Employment based upon race, color, religion, ancestry, age (40 and above), sex, national origin, non-job related handicap or disability, known association with a handicapped or disabled individual, possession of a diploma based on passing a general education development test, or willingness or refusal to participate in abortion or sterilization.

IN-17 FORM - NON-JOB RELATED DISABILITY QUESTIONNAIRE

Questionnaire on the incident you are complaining about

To avoid rewriting your answers, please read this short questionnaire from beginning to end before filling out your answers to individual questions. Please answer every applicable question as fully as possible, and to the best of your present knowledge, information and belief. If you are unsure of your answer, please say so. It is your responsibility to notify this Agency of a change of address or times of unavailability. Failure to notify this Agency may result in dismissal of the matter.

Name _____

Address _____

City _____ State _____ Zip Code _____

County _____ Phone H: _____ Phone W: _____

May we call you at work? (Circle one) **YES** **NO**

Caution: Failure to correctly identify the name of the legal entity you are complaining about will hinder the processing of your complaint. Bring pay stubs, W-2 forms, contracts, etc. to aid in verification of the name and address.

Information about the Organization your complaint is against:

Name _____

Address _____

City _____ State _____ Zip Code _____

Type of Business _____

County _____ Phone No. _____

Number of employees who work at the organization named above. Please circle one.

- | | | | |
|-------------|------------|------------|---------|
| Less than 4 | 15 to 100 | 201 to 500 | Unknown |
| 4 to 14 | 101 to 200 | 501 plus | |

Name and address of person who will know how to contact you and who does not reside in your home.

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone No. Home _____ Phone No. Work _____

In this Questionnaire, you will see the word "class" mentioned. **Class means the person's race, sex, age, ancestry, religion and so on.** Depending on the issues in the complaint, you may belong to two or more classes. For example, a Black female could belong to two classes: race/Black and sex/female. A White male could belong to race/White and sex/male. All persons named in the complaint or questionnaire should be identified by their class as follows: John Doe (White male), John Doe (under age 40), Jane Doe (Black female). or example, if your complaint is based on race, include the race of all persons mentioned. If it is a sex complaint, mention the sex of all persons mentioned.

1 **Discrimination means difference of treatment.** Please explain what happened to you and why you feel you were treated differently. In other words, what happened to persons of a different class that makes you feel they received more favorable treatment than you. Give specific dates.

2 If you believe the organization treated you this way because of one or more of the reasons listed below, please check those reasons. If you believe the employer treated you this way for a reason which is not listed, explain what you believe to be the reason.

- _____ Sex _____ National Origin
- _____ Race _____ Age Date of Birth _____
- _____ Color _____ GED
- _____ Religion _____ Retaliation
- _____ Ancestry _____ Use of guide dog or support animal
- _____ Non-job related disability

Identify your disability: _____

_____ Participation in/or refusal to participate in Abortion/sterilization

3 Describe your disability. Provide the medical name for your disability, if known, as well as a general description of your disability in non-medical terms. Describe in general what major life activities (such as walking or lifting) are affected by your disability and describe the extent to which that activity is affected.

4 Is your disability permanent? **YES** **NO**

4a Or temporary? **YES** **NO**

5 How long is your condition expected to last? _____

When was your disability first diagnosed? Give date. _____

Was it caused by injury or accident? **Injury** **Accident**

Date this injury/accident occurred? _____

Is your disability improving? **YES** **NO**

Is your disability worsening? **YES** **NO**

6 If your disability was caused by or made worse by a job-related injury or accident, did you apply for workers compensation? **YES** **NO**

6a If yes, were you awarded workers compensation? **YES** **NO**

6b For what period of time were you on workers compensation?
_____ **Years** _____ **Months** _____ **Days**

6c If you are still on workers compensation (or were on workers compensation at the time of the alleged discrimination), explain how you would be able to perform the essential functions of your regular job with or without an accommodation while still on workers compensation.

7 Describe the job in question and explain how your particular disability affects your ability to perform this job. _____

7a Describe any limitations or restrictions related to this job which have been placed on you by a physician for reasons related to your disability. _____

7b If your physician recommended that you be place on "light duty", what type of light duty assignments were recommended and for what period of time? _____

7c Does the Respondent (your employer) have a light duty program? **YES** **NO**

7d If so, is this duty limited in any way (e.g., only to persons who had on-the-job injuries, for a limited period of time, for certain categories of employees only, etc.)

8 Have you received any rehabilitation, in the form of specialized training to perform a job similar to the position in question? **YES** **NO**

If yes, describe the nature of this training. _____

9 Describe how, when and which Respondent management officials became aware or your disability and any job-related limitations or restrictions caused by that disability.

10 Have any Respondent managers or supervisors made negative comments concerning your disability? **YES** **NO**

10a If so, provide the name and title of each person making the comments and describe those comments in terms of what was said, when it was said and whether there were any witnesses to those statements.

Name _____

Title _____

CLASS _____

Comments Made _____

Name _____

Title _____

CLASS _____

Comments Made _____

10b Who witnessed this?

Name/Title _____

Name/Title _____

Name/Title _____

11 Do you (or did you) need a reasonable accommodation in order to perform the job in question?

YES NO

If yes, please describe the accommodation made. _____

11a If yes, describe for what part or parts of the job you required an accommodation.

11b Indicate how frequently this part of the job is done and the importance of this part of the job to the total job.

12 Are you (or were you) able to perform all parts of the job in question other than the part(s) described above for which you require an accommodation?

YES NO

12a What were the major functions you were able to perform without an accommodation?

13 What types of physical activity are difficult or impossible for you to perform? (Please circle.)

- | | | | |
|---------|----------|-----------|---------------------------|
| Visual | Bending | Dexterity | Standing for long periods |
| Hearing | Stooping | Running | Sitting for long periods |
| Walking | Turning | Swallowin | Performing manual tasks |
| Lifting | Climbing | Other** | Caring for yourself |

If **other, please explain.

Please provide copies of any medical information, certifications, etc. regarding your disability.

14 Do you have any restrictions on mental activities? YES NO

If yes, please explain.

14a Please provide names and addresses of doctors, hospitals, counselors, organizations, etc., who may be able to provide data concerning your disability and the extent of any treatment or specialized training you have had or are receiving.

Name/Title _____

Address _____

Treatment/Training _____

Name/Title _____

Address _____

Treatment/Training _____

Name/Title _____

Address _____

Treatment/Training _____

14b Please provide specific dates and reasons, for each occasion in the last two years, you have been admitted to any hospital/medical facility.

Date _____

Reason _____

Date _____

Reason _____

Date _____

Reason _____

Date _____

Reason _____

14c Are you currently taking any prescribed drugs related to your handicap/disability? **YES** **NO**

If yes, please specify the name of the drug(s), the dosage taken and the name of the prescribing physician.

Drug _____ Dosage _____

Prescribing Physician _____

Drug _____ Dosage _____

Prescribing Physician _____

Drug _____ Dosage _____

Prescribing Physician _____

Drug _____ Dosage _____

Prescribing Physician _____

14d Are you currently receiving medical treatment of any kind? **YES** **NO**

If so, name the doctor/hospital, how often the treatment is given and is it given during the day or evening hours.

Doctor/Hospital _____

How Often _____ Day Evening

Doctor/Hospital _____

How Often _____ Day Evening

Doctor/Hospital _____

How Often _____ Day Evening

14e If you receive such treatment(s), is it during potential working hours? **YES** **NO**

How long are the treatment visits? _____

Can the hours be changed as not to conflict with employment? **YES** **NO**

How often are the treatment visits? _____

What is the effect of the treatment or of any medication that may be taken during this treat

Was the Respondent aware of this? **YES** **NO**

If yes, under what circumstances, and what comments were made at that time?

15 Did you request a reasonable accommodation? **YES** **NO**

15a When did the employer become aware of the certification that you could perform the job with or without reasonable accommodation? _____

15b From whom did you request a reasonable accommodation?

Name/Title _____

Please provide a copy of the written request, if you have one.

15c Was any cost attached to this reasonable accommodation? **YES** **NO**
 If yes, approximately how much would these accommodations cost, including special equipment, building renovations and work force changes?

16 Did the Respondent refuse the request for a reasonable accommodation? **YES** **NO**

If yes, who refused it, when was it refused and what reason was given for the refusal?

Name/Title _____

Date _____

Reason _____

17 Did the Respondent offer another or different accommodation? **YES** **NO**

If yes, What was the accommodation offered? _____

17a Did you and/or your doctor refuse this offer? **YES** **NO**

If yes, why? _____

18 Did the Respondent inquire either orally or on its application about past handicap/disability, current handicap/disability or both? **YES** **NO**

If yes, which? Orally Application Both

19 What specific inquiries were made and what were your responses to each?

Inquiry _____

Response _____

Inquiry _____

Response _____

Inquiry _____

Response _____

20 If the Respondent inquired about current handicap/disability, did the Respondent inquire beyond the mere existence of such handicap/disability to determine the extent to which it might interfere with your ability to perform the job responsibilities? **YES** **NO**

21 Was there any discussion of accommodations that might be made to enable you to perform the job responsibilities? **YES** **NO**

If yes, please explain. _____

22 Have you ever been employed in a position requiring substantially the same duties or responsibilities as the position in question? **YES** **NO**

If yes, please describe the job duties.

Date _____

Employer _____

Job Title/Dept. _____

Duties _____

22a Was the Respondent aware of this? **YES** **NO**

If yes, what was the Respondent's comments _____

23 When you were employed in the past, what restrictions were placed on your job responsibilities because of your handicap/disability? _____

23a Do you feel that this was justified? **YES** **NO**

23b Who placed these restrictions on your job responsibilities? (Please Circle)
You Your Doctor Your Employer Your Employer's Doctor

24 Do you have a physician, health service or rehabilitation clinic that has/will certify that you can perform the job in question with or without reasonable accommodation? **YES** **NO**

If yes, please give names and addresses.

Name/Title _____

Address _____

Name/Title _____

Address _____

Name/Title _____

Address _____

25 If you are claiming that you are not disabled, but Respondent incorrectly "perceived" you to have a disability, describe what disability you are perceived as having.

25a Indicate which Respondent representative(s), by name and job title, perceive you to have this disability and what makes you believe that those persons have this perception.

Name/Title _____

Reason _____

Name/Title _____

Reason _____

26 If the Respondent has taken an action against you because you are viewed as being a "direct threat" (i.e., that because of your disability you posed a threat to your own safety or the safety of co-workers), provide the name and title of the Respondent representative who informed you of this.

Name/Title _____

26a When did this occur? _____

26b Was this done verbally or in writing? **verbally** **writing**

26c What reason(s) was given for considering you a direct threat? _____

26d Was a reasonable accommodation offered? **YES** **NO**

27 Does the employer require employees to undergo pre-employment medical examinations? **YES** **NO**

28 Did the Respondent in any manner, or based on past practices, indicate that any other factors were involved in the decision to deny, limit or withhold employment, such as age, race, national origin, etc? **YES** **NO**

If yes, please explain. _____

**A Medical Release Form is enclosed for your signature. Please read the form before signing.
If you do not sign the Medical Release Form, please explain why.**

If there are other facts you feel should be considered, record these on the last page of the questionnaire (Continuation Page).

I hereby verify that the statements contained in this complaint are true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 PA.C.S. Section 4904, relating to unsworn falsification to authorities.

Signature _____ Date _____

Address _____

City, State and Zip Code _____

Phone No. Home _____

Phone No. Work _____

Phone No. Cell _____

