Please return completed PART A and documents requested in PART B to the Office of Employee Relations, fax: (303) 735-3236 or mail, 565 UCB

REASONABLE EMPLOYER INFORMATION SHEET

PART A (Please answer all of the following questions)

Employee name:	
Employee title:	
Date hired in position:	
Total length of service (with State or CU):	
Date injury/illness occurred:	
Is the injury/illness an on-the-job injury (OJI)?	☐ **Yes** ☐ **No**
If the illness/injury is an OJI, has the employee been placed at maximum medical improvement (MMI)?	☐ **Yes, the employee was placed at MMI on .** ☐ **No**
Has the employee's health care provider placed restrictions on the employee's ability to return to work?	☐ **Yes, the employee has been given the following:** ☐ **Temporary restrictions** ☐ **Permanent restrictions** ☐ **No**
If the restrictions are temporary, does the supervisor or appointing authority believe the department is able to offer the employee a temporary work assignment?	☐ **Yes** ☐ **No, the department does not believe it is able to offer the employee a temporary work assignment for the following reasons:**

If the restrictions are permanent, does the supervisor or appointing authority believe the department is able to accommodate the employee's restrictions in his/her position moving forward?	☐ **Yes** ☐ **No, the department does not believe it is able to accommodate employee's restrictions for the following reasons:**
Has the employee requested a workplace modification or reasonable accommodation to assist him/her in performing the essential functions of the job?	☐ **Yes, the employee has requested the following workplace modification or reasonable accommodation:** ☐ **No**
If the employee has requested a workplace modification or reasonable accommodation has the ADA Coordinator been contacted?	☐ **Yes** ☐ **No**
Please provide the employee's date of exhaustion or anticipated date of exhaustion for the following applicable forms of leave/ comp time:	☐ **Sick: _____** ☐ **Annual: _____** ☐ **FML:_____** **If applicable:** ☐ **STD:_____** ☐ **OJI: _____** ☐ **Make Whole:_____** ☐ **Comp Time: _____**

PART B (Please provide the following documents)

For an employee with an on-the-jobs injury/illness:

1. The employee's most recent worker's compensation disposition report
2. Any other worker's compensation disposition reports that show the date the employee was placed at MMI or that outline any temporary or permanent restrictions the employee has been given (if not included in the most recent disposition form)
3. The employee's PDQ/job description

For an employee with a non-work related injury/illness:

1. The employee's most recent FML medical certification form
2. Any Fitness to Return to Work forms the employee has provided that describe any temporary or permanent restrictions the employee has been given
3. The employee's PDQ/job description