Revised 07/27/2011

IMPORTANT—PLEASE READ THIS FIRST.

This form provides information to the South Dakota Department of Labor & Regulation, Division of Human Rights.

This form is not a formal charge of discrimination.

Please print or type answers to all questions.

You must sign and date this form.

INTAKE QUESTIONNAIRE FOR POTENTIAL DISABILITY DISCRIMINATION COMPLAINT

For
Discrimination in Employment

Question 1:

A. Your name: _____ _____ _____
(First) (Middle Initial) (Last)

B. Your date of birth: _____

C. Your type of disability: ☐ physical ☐ mental ☐ both physical and mental

D. Your major life activity that has been affected: (Choose all that apply.)

- ☐ seeing
- ☐ hearing
- ☐ eating
- ☐ sleeping
- ☐ walking
- ☐ standing
- ☐ sitting
- ☐ reaching
- ☐ lifting
- ☐ bending
- ☐ speaking
- ☐ breathing
- ☐ learning
- ☐ reading
- ☐ concentrating
- ☐ thinking
- ☐ communicating
- ☐ interacting with others
- ☐ working
- ☐ major bodily function (including the operation of an individual organ within a body system)
- ☐ other _____

Question 2:

Describe all major life activities (see list in Question 1D) that you cannot perform.

Question 3:

Describe all medical restrictions you have been placed on by a medical professional.

Question 4:

Describe any side effects you have from using medications to control your symptoms.

Question 5:

A. If you have been medically diagnosed as having a permanent or long-term physical or mental disability, will you give us a copy of your doctor's diagnosis or sign a release so that we can get a copy? ☐ Yes ☐ No (If you have a copy available, please attach it to this form.)

B. What is your doctor's medical diagnosis of your condition?

C. What is your doctor's prognosis for your recovery? In other words, how long might it take you to get well?

D. What is your doctor's name and address?

Question 6:

A. Did the employer ask you questions about your disability or about your use of sick leave or workers' compensation benefits? (Check all that apply.)

- ☐ on an application form
- ☐ before a conditional job offer was made
- ☐ at any time during the employment relationship

B. If you checked any of the above, please provide detailed information on each incident:

Question 7:

A. Were you required to take a medical exam before a job offer was made? ☐ Yes ☐ No

If no, at any time were you required to take a medical exam that other employees or job applicants were not required to take? ☐ Yes ☐ No

B. Were any required medical exams job-related? ☐ Yes ☐ No

Explain how any required medical exams were or were not job-related.

Question 8:

A. Is/Was the employer aware of your disability? ☐ Yes ☐ No

B. Does the employer have a record of your disability? ☐ Yes ☐ No

What kind of record is this?

What is(are) the date(s) of this record?

How did the employer know about your disability?

Question 9:

A. What was the job title of the position you held or applied for?

B. Are/Were you qualified for this position? ☐ Yes ☐ No

C. Describe the qualifications necessary for the job:

education

experience

skills

other

D. What are/were the job duties or most important functions of the job?

E. Are/Were you able to perform these duties or functions? ☐ Yes ☐ No

F. Are/Were you able to do the most important functions of your job satisfactorily? ☐ Yes ☐ No

G. Would you have needed any reasonable accommodations in order to do the job? (Examples of a reasonable accommodation are listed in Question 11E.) ☐ Yes ☐ No

If yes, describe what accommodation(s) you would have needed.

Question 10:

A. Do/Did you have regularly scheduled performance evaluations? ☐ Yes ☐ No

If yes, what ratings did you receive on your last two performance evaluations? (List ratings and the dates, if known.):

B. If we find that we need them, will you give us copies of your last two performance evaluations? ☐ Yes ☐ No

Question 11:

A. Do/Did you need any reasonable accommodations in order to do the job? (Examples of a reasonable accommodation might include those listed below.) ☐ Yes ☐ No

If yes, describe what accommodation(s) you needed.

B. Did you ever request to be accommodated by the employer so that you could perform your job? ☐ Yes ☐ No

If yes, who did you talk to and when? (List name, job title, and date.)

What accommodations did you request?

C. Did your employer try to provide accommodation? ☐ Yes ☐ No

If yes, when?

Was the accommodation

- ☐ offered?
- ☐ considered effective?
- ☐ accepted?
- ☐ rejected?

D. Explain who offered the accommodation, considered it effective, accepted it or rejected it.

E. If you need reasonable accommodation to do the most important functions of your job, what type of accommodation is required? (Check all that apply.)

- ☐ restructure job
- ☐ reassign duties
- ☐ modify schedule
- ☐ adjust leave policy
- ☐ provide equipment
- ☐ modify policies
- ☐ provide interpreters
- ☐ provide personal assistant
- ☐ reassign elsewhere
- ☐ assign to temporary light duty

Explain why each selected accommodation is necessary.

Question 12:

A. If you were fired or laid off, did your employer send you a notice of discharge?
☐ Yes ☐ No

If yes, please attach a copy of it to this form. If no, describe the reason your employer gave for discharging you.

B. Did your employer hire someone else to fill your position? ☐ Yes ☐ No

If yes, what is this person's name and disability status (if known)?

REMEMBER: Completing this Intake Questionnaire does not file your charge. This form is a fact-gathering information tool that we need in order to write the formal Charge of Discrimination.

By signing this form, you are saying that you have told the truth in all your answers here.

I declare and affirm under the penalties of perjury that this information has been examined by me and, to the best of my knowledge and belief, is in all things true and correct.

_____ _____

SIGNATURE OF POTENTIAL CHARGING PARTY

DATE

PRIVACY ACT STATEMENT: (This form is covered by the Privacy Act of 1974, Public Law 93-579. Authority for requesting the personal data and the uses there are given below.)

FORM NUMBER/TITLE/DATE: DENDO TEST FORM 283. Intake Questionnaire, ADA Supplement, July 1994.

AUTHORITY: 42 USC 12117, 42 USC 2000c-5(b), 29 U.S. Section 211, 29 U.S.C. Section 626.

PRINCIPAL PURPOSES: The purpose of this questionnaire is to solicit information to enable the Division of Human Rights to draft a charge, if appropriate, and to avoid the intake of matters not within its jurisdiction.

ROUTINE USES: Information provided on this form will be used by Division of Human Rights employees to determine the existence of facts relevant to a decision as to whether the Division of Human Rights has jurisdiction over potential charges, complaints or allegations of employment discrimination and to provide such pre-charge filing counseling as is appropriate. Information provided on this form may be disclosed to federal agencies as may be appropriate or necessary to carrying out the Division of Human Rights' functions. This would include employment practices laws. Information may also be disclosed to charging parties in consideration of or in connection with litigation.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION: The providing of this information is voluntary but the failure to do so may hamper the Division of Human Rights' investigation of a charge of discrimination. It is not mandatory that this form be used to provide the requested information.