# NAME OF COMPANY/ORGANIZATION
## Employee Self-Identification Form

TO BE COMPLETED BY ALL EMPLOYEES AND RETURNED TO:
Human Resources Department
ADDRESS, CITY, STATE, ZIP

Please Print:

Name:_____ Date:_____

Department:_____

NAME OF COMPANY/ORGANIZATION has adopted an Affirmative Action Plan in order to ensure Equal Employment Opportunity for all. The disclosure of the following information is voluntary and allows us to meet government reporting requirements and judge the effectiveness of our recruitment efforts. The information will be used in accordance with NAME OF COMPANY/ORGANIZATION policies and State and Federal law, which forbid discrimination based on this information.

If you do not provide racial/ethnic heritage information, federal regulations stipulate that a visual survey or post-employment records may be used to acquire racial/ethnic heritage information necessary for the completion of affirmative action records.

**Sex/Gender:** *(Check one)*

- ☐ Female
- ☐ Male
- ☐ Non-Binary

**Race/Ethnic Heritage:** *(Check one or more)*

- ☐ **American Indian or Alaskan Native**
  All persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal association or community recognition.
- ☐ **Asian or Pacific Islander**
  All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.
- ☐ **Black or African American** (Not of Hispanic Origin)
  All persons having origins in any of the black racial groups of Africa.
- ☐ **Hispanic or Latino**
  All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- ☐ **White** (Not of Hispanic Origin)
  All persons having origins in any of the original peoples of Europe, North African or the Middle East.
- ☐ **Other** (Specify)_____

**NAME OF COMPANY/ORGANIZATION**

***INTER-DEPARTMENTAL***

**CORRESPONDENCE**

DATE: MONTH, DAY, YEAR

TO: All COMPANY/ORGANIZATION Employees

FROM: OCCUPATIONAL ACCOMMODATIONS SPECIALIST, HUMAN RESOURCES

SUBJECT: **Self-Declaration of Disability Form**

It is COMPANY/ORGANIZATION policy to provide equal employment opportunities for all persons. Under Federal law and City ordinances, NAME OF COMPANY/ORGANIZATION has the responsibility to collect workforce data about the number of employees who have a disabling condition.

The Self-Declaration of Disability Form is used to determine how many persons with disabilities are represented in our workforce. The information requested is intended for use in connection with COMPANY/ORGANIZATION's voluntary affirmative action efforts. Although COMPANY/ORGANIZATION is required to collect this information, disclosing a disability is **voluntary** on the part of the employee. Verification of disability is only required when a reasonable job accommodation is requested.

Your completed form will not be filed in your personnel file. The Occupational Accommodations Specialist in the Human Resources Department will retain it in a separate file. All information provided shall remain **confidential** and will not be released to anyone without prior written permission of that individual, and would only be used to secure positive employment benefits. Your refusal to provide the information will not subject you to any adverse treatment.

Please complete the attached Self-Declaration of Disability Form whether or not you wish to declare a disability, and seal it in the attached confidential envelope.

If you have any questions or concerns, please feel free to contact OCCUPATIONAL ACCOMMODATIONS SPECIALIST at PHONE NUMBER or EMAIL ADDRESS.

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**DEFINITION OF "DISABILITY"**

**Americans with Disabilities Act (ADA)**

An individual with a disability is a person who:

a. Has a permanent physical or mental impairment that substantially limits one or more major life activities;
b. Has a record of such impairment; or
c. Is regarded as having such impairment.

**Wisconsin Fair Employment Act (WFEA)**

An individual with a disability is a person who:

a. Has a physical or mental impairment which makes achievement unusually difficult or limits the capacity to work;
b. Has a record of such impairment; or
c. Is perceived as having such impairment.

**USE OF THE SELF-DECLARATION OF DISABILITY FORM**

1. The Self-Declaration Form alerts the Occupational Accommodations Specialist of an employee with a disability, whether or not any modifications may be needed.
2. Disabilities that are declared may be grouped by Job Family and utilized by COMPANY/ORGANIZATION for goal setting. In order to maintain confidentiality, specific names are not released. COMPANY/ORGANIZATION shall only advise a department/division of those Job Families wherein hiring goals should target the recruitment and selection of individuals with disabilities.

# COMPANY/ORGANIZATION SELF-DECLARATION OF DISABILITY FORM

Last Name First Initial

Department/Division

Work Telephone

Date of Hire Work Status: Perm
Hourly/Seasonal

Job Title

**NOTICE TO COMPANY/ORGANIZATION EMPLOYEES:** *Declaring a disability for employment purposes is voluntary and is only used to assist us in meeting COMPANY/ORGANIZATION'S Affirmative Action efforts. Completion and return of this form is required.* ***Complete only section A if no disability is declared.*** *Information provided on this form shall be maintained within the bounds of professional confidentiality. Any information provided about a disability will only be used to secure positive employment benefits and will not be released without your prior written permission. Refusal to provide the information will not subject you to any adverse treatment.*

**INSTRUCTIONS: READ THE INFORMATION ON THE FRONT OF THIS FORM REGARDING THE DEFINITION OF DISABILITY AND THEN COMPLETE EITHER A or B.**

**A. I DO NOT WISH TO DECLARE A DISABILITY**

Signature Date

**B. I WISH TO DECLARE A DISABILITY FOR EMPLOYMENT PURPOSES.**

1. What is the nature of your condition(s)?

2. Are there any modifications in your current workplace, the equipment you use, or how your work is done that would help you do your job more efficiently and/or effectively? No Yes Please specify:

3. Do you wish to be contacted by the COMPANY/ORGANIZATION's Occupational Accommodations Specialist?
No Yes *Note: All contacts can be made in a confidential manner at your home address.*

Signature Date

Home Address ZIP Home Phone

**PLEASE SEAL THIS FORM IN THE ATTACHED ENVELOPE AND RETURN IT BY INTERDEPARTMENTAL MAIL TO:**
Occupational Accommodations Specialist,
ADDRESS, CITY, STATE ZIP
**PHONE NUMBER**