Department of Defense and Smithsonian Institution
Accommodation Request Form

The Smithsonian Institution signed an interagency agreement with the Department of Defense Computer/Electronic Accommodations Program (CAP) making its employees eligible for CAP services at no cost to the Institution. CAP pays for and provides a wide variety of assistive technology for people with hearing, visual, dexterity, cognitive or communication disabilities. Frequently requested accommodation solutions include teletypewriters (TTY’s), captioning for training videos, print enlargers, screen readers, alternative keyboards, pointing devices, and speech recognition software. CAP also funds sign language interpreters, readers, and personal assistants for Federal employees needing to attend technology related training sessions that last two or more days. Information on CAP services is available at www.tricare.osd.mil/cap.

The process for customers to identify and request accommodations from CAP is simple. First, we strongly recommend a needs assessment to determine the best and most current technology for your condition. The needs assessment is conducted to identify accommodations suitable for an individual’s specific situation. CAP staff works with employees and their supervisors to conduct a proper needs assessment. CAP also maintains the “CAP Technology Evaluation Center” (CAPTEC) where employees and their supervisors can evaluate and become familiar with assistive technology and facilitate the process of choosing the appropriate equipment. Call CAPTEC at (703) 693-5160 for more information or to schedule an appointment.

Following the completion of the needs assessment, the attached, two-page “CAP Request Form” is completed by the employee. Medical documentation from the employee’s physician is required for 21 inch monitors and ergonomic requests. The Smithsonian may request additional medical documentation. The employee and his/her supervisor must sign the form. The Disabled Employees Program Manager in the Smithsonian’s Office of Equal Employment and Minority Affairs will review and sign the form and submit it to CAP. The signatures certify that the accommodation is necessary for the person with a disabling condition to accomplish essential job requirements.

The completed form and supporting information should be faxed or sent to:
Office of Equal Employment and Minority Affairs
750 Ninth Street, Suite 8100
Washington, DC 20560
FAX: (202) 275-0160

CAP orders the equipment and it is shipped directly to the employee within 7 to 10 days if the accommodation is appropriate. The item requested becomes the property of the Smithsonian Institution. Furthermore, equipment maintenance beyond initial warranty period and additional supplies after receipt of equipment is the responsibility of the Smithsonian.

If you have any questions, please call Laura Conway, SAO EEO Officer at 5-7373 or OEEA at (202) 275-0145 (Voice) or 202-275-0756 (TTY). You may also contact CAP at 703-681-8813 (Voice), 703-681-3978 (TTY) or e-mail CAP@tma.osd.mil.
CAP Office Use Only

Received: __________ [ ] EFMP [ ] Flexi
Completed: __________ [ ] DDESS [ ] WC
Ordered: ____________ [ ] DoDDS [ ] CTRS
Declined: ____________ [ ] MTF
Order #: ___________
Vendor: _______________________________
Item Description: ________________________

Department of Defense & Smithsonian Institution
Accommodation Request Form

Please Print

1. PERSON OR OFFICE TO BE ACCOMMODATED:
   Last Name: ____________________________ First Name: ____________________________
   Museum/Research Institute/Office: ____________________________
   Position Title: ________________________ Grade Level: ____ Occupational Series: _______________
   Are you a new federal employee? _______       Are you a new Smithsonian employee? _______

2. OFFICE LOCATION: (No acronyms)
   Address: __________________________________ Room Number: ________ MRC: _______
   City, State, Zip Code: _______________________________________________
   Telephone # (Please indicate if TTY): _______________________ Fax #: _______________
   E-mail Address: __________________________________________

3. DISABILITY INFORMATION:
   Circle your disability:
   Deaf/Hard of Hearing  Blind/Low Vision  Cognitive  Dexterity
   Other Disability (Explain): ______________________________________________

   Please note: Medical documentation of legal blindness from the employee’s physician is required by CAP for 21 inch monitors. CAP also requires medical documentation of your disability if it is ergonomic related. The Smithsonian may request additional medical documentation. For more information, contact Laura Conway, SAO EEO Officer at 5-7373 or the Smithsonian’s Disabled Employees Program Manager at (202) 275-0150 (voice) or (202) 275-0756 (TTY).

   Include your Workers’ Compensation Claim #, if applicable: ______________________________
   (Please attach the Department of Labor Claim Acceptance Letter to this form.)
   Is this accommodation for a workstation in an approved flexiplace location? If yes, where? ___________

   *** REQUESTS FOR EQUIPMENT ***

4. ITEM REQUESTED: Complete this section only if you are requesting equipment. Include brand name/model and attach any vendor information/brochures you may have (one item per request form). If requesting Speech Recognition Software, please complete and fax the “Speech Recognition Information Form,” located under “News - Documents” on the CAP website at http://www.tricare.osd.mil/cap/sitemap.htm. (The speech recognition form may be signed by the person in your unit who provides computer support.)
Accommodation Request Form Page 2

Have you had a needs assessment with CAP? _______  If not, how did you determine the need for this item? ____________________________________________

JUSTIFICATION: Explain how your disability is affecting your work:_________________________
_________________________________________________________________________________
_________________________________________________________________________________

Please explain how this item will assist you in completing the essential functions of your job.
_________________________________________________________________________________

COMPUTERSYSTEM CONFIGURATION: Identify your computer’s operating system.
Win00___  Win98 ____  Win95 ____  Win3.x ____  Mac ____  DOS ____  Other ____

Do you need assistance with installation or training on the new equipment? ________________

5. FUNDED SERVICE: Complete this section only if you are requesting a funded: Reader, Interpreter, and Personal Assistant. These services are provided only to customers when they attend technical classes or conferences to obtain new computer-related skills. A training session or travel must last two or more days. Please submit a fully completed request at least 15 days prior to the start of the training or travel. Complete sections A and B. Identify which funded service you are requesting from the list above. ________________

A. Training Session:
Training Provider/Sponsor: _____________________________________________________________
Training Course Title: __________________________________________________________________
Course Location: _____________________________________________________________________
Course Dates: ______________________________________________________________________

B. Information on Service Provider (Interpreters, Readers, etc.):
For interpreting service information refer to the CAP Interpreter Database, located under “Deaf Accommodation Services” on the website. For information on obtaining a personal assistant, refer to the CAP Personal Assistant Guidelines, located under “News - Documents” on the website.

Agency/Service Provider Name, Point of Contact and Address:
_______________________________________________________________________________________
Telephone/TTY #: ____________________________  Fax #: ____________________________
Cost/Quote (please attach): ____________________  Does service accept Credit Card Payment? ______
E-Mail Address: ____________________________  Website: ________________________________

* * *  SIGNATURES  * * *

6. Signatures: Signing this form signifies you agree to CAP terms and conditions.
Employee Signature: ____________________________  Date: ____________________________
Supervisor’s Name: ____________________________  Title: ____________________________
Supervisor’s Signature: ____________________________  Date: ____________________________
Supervisor’s Telephone/TTY #: ____________________________  Fax #: ____________________________
Signature - Disabled Employee’s Program Manager (OEEMA): ____________________________
Please Print
Employee’s Name: _______________________________________________________
Smithsonian Unit: ________________________ Work Phone Number: ______________

This form is for use by the Department of Defense’s Computer/Electronic Accommodations Program in support of Smithsonian Institution employees who request accommodations through their program. Medical **documentation is required for requests** for **21 inch monitors and ergonomic equipment under CAP’s program**.

It is probably not necessary for you to undergo a new medical examination for the completion of this form if your condition has been evaluated recently enough to provide current information. You need only give a copy of this form to your physician and ask the physician to complete the section below. The form may be returned to you for your submission with the CAP/SI Accommodation Request Form (this supplement does not have to be reviewed by your supervisor). The provision of this information is entirely at your discretion and expense. It is your responsibility to ensure that this document is submitted on a timely basis if you want it to be considered. If you have any questions about this request, please contact Laura Conway, SAO EEO Officer at 5-7373 or The Office of Equal Employment and Minority Affairs at 202-275-0145 (voice) or 202-275-0756 (TTY).

Please ask your physician to provide the following information (a separate sheet may be attached):

☐ Medical diagnosis of legal blindness

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

-OR-

☐ Medical diagnosis of ergonomic-related condition

__________________________________________________________________________________
__________________________________________________________________________________

____________________________________________________

Physician’s Name: _______________________ Phone Number: ___________________
Physician’s Signature: ___________________________ Date: ____________________

I authorize my physician to provide the above information.

Employee's Signature: ___________________________ Date: ____________________