## **Voluntary Self-Identification of Disability**

Form CC-305 OMB Control Number 1250-0005

Page 1 of 1xx/xx/x	xxxExpires			
Name: Employee ID:		Date:		
p.:0,00 .2.	(if applicable)	_		
Why are you being asked to complete this form?				

We are toby law required or subcontractor a federal contractorprovide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least. To do this, we must ask applicants and employees if they7% of our workforce be individuals with disabilities have a disability or have ever had a disability.

Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability . <a href="www.dol.gov/ofccp">www.dol.gov/ofccp</a> HYPERLINK "http://www.dol.gov/ofccp" ederal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at fFor more information about this form or the equal employment obligations of regardless of whether you have self-identified in the past., you in any waynegatively impact will not. Completing the formmaking personnel decisions and not be seen by selecting officials or anyone else involved in lyconfidentialmaintained answer will be rouy. do sowe hope that you will choose to and is voluntary,

## How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. Disabilities include, but are not limited to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDSor
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing

- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease irritable bowel syndrome or,
- Intellectual disability
   Missing limbs or partially missing
   limbs
- •
- Nervous system for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)condition
- Psychiatric, for example, bipolar disorder, schizophrenia, PTSD, or major depressioncondition

<del>Disa</del>	<del>pilities include, but are not limited to:</del>
•	•
•	• • • Please check one of the boxes below:
•	Flease check one of the boxes below.
• [	• • • 1
_	Yes, I Have A Disability, Or Have A
	History/Record Of Having A Disability
	No, I Don't Have A Disability, Or A
	History/Record Of Having A Disability I Don't Wish To Answer
	1 Boilt Wish 10 / Howel
to a	LIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond collection of information unless such collection displays a valid OMB control number. This survey should take about 5 tes to complete.
	For Employer Use Only
	Employers may modify this section of the form as needed for recordkeeping purposes.
	For example:
	Job Title: Date of Hire: