_	Voluntary Self-Identification of Disability
	m CC-305 OMB Control Number 1250-0005 e 1 of 1 Expires 05/31/2023
Nar	me: Date:
Em	ployee ID:
	(if applicable)
	Why are you being asked to complete this form?
with with Bed	e are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people in disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals in disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Cause a person may become disabled at any time, we ask all of our employees to update their information at least ery five years.
Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal 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 www.dol.gov/ofccp .	
	How do you know if you have a disability?
limi	 a are considered to have a disability if you have a physical or mental impairment or medical condition that substantially its a major life activity, or if you have a history or record of such an impairment or medical condition. Disabilities lude, but are not limited to: Autism Deaf or hard of hearing Depression or anxiety Diabetes Diabetes Epilepsy Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome Celiac disease Cerebral palsy Missing limbs or partially missing limbs Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS) Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression PTSD, or major depression
	Please check one of the boxes below:
to a	
	For Employer Use Only
	Employers may modify this section of the form as needed for recordkeeping purposes.
	For example:
	Job Title: Date of Hire: