

## Voluntary Self-Identification of Disability

Form CC-305  
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OMB Control Number 1250-0005  
Expires xx/xx/xxxx

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Why are you being asked to complete this form?

This employer is a federal contractor or subcontractor required by law to reach out to, hire, and provide equal opportunity to qualified people with disabilities. We must make reasonable efforts to have at least 7% of our workforce be individuals with disabilities. To help us measure how well we are doing, we invite you to tell us if you have a disability or if you ever had a disability. Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. If you are applying for a job, any answer you give will be kept private and separate from the selection process. It will be maintained in a confidential file 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.

Because a person may become disabled at any time, we must ask all of our employees to update their information at least every five years. If you already work for us, your answer will not negatively impact you in any way, regardless of whether you have self-identified in the past. Again, the information you provide will be maintained in a separate, confidential file. 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](http://www.dol.gov/ofccp).

### 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/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Cerebral palsy
- Deaf or hard of hearing benefiting from hearing aid(s)
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome, celiac disease
- Intellectual disability
- 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

### Please check one of the boxes below:

- YES, I HAVE A DISABILITY, OR HAVE A HISTORY/RECORD OF HAVING A DISABILITY
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

**PUBLIC BURDEN STATEMENT:** According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.