Employee Request for Disability-Related Reasonable Accommodation

Dear Employee:
To request a reasonable accommodation please:

1) **Complete and sign** the this form, the accompanying *Authorization for Release of Medical Information* form, and have your healthcare provider complete and submit the *Request for Healthcare Provider Response* form.
2) Note it is your responsibility to ensure the timely receipt of all forms by the Benefits team in the Department of Human Resources. The Sr. Benefits Specialist in the Department of Human Resources will schedule an interactive process meeting as soon as you submit your accommodation request and the completed accompanying forms.

Employee Information

Employee______________________________________ Position ______________________________

Department____ Extension__________

Supervisor ____

Request *(do not provide confidential medical information or diagnosis information)*

I request the following accommodation(s):

a) ____

b) ____

c) ____

d) ____

To assist the University in performing the ADA reasonable accommodation analysis, please answer the following questions:

1) Do you have a physical or mental condition that is impairing life activities? ___________

2) If the answer to 1 is yes, please identify the nature of the impairment (do not disclose medical diagnosis only nature of impairment):
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3) Does this condition/disability impair your ability to perform your job functions? If yes, please explain:

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4) If the answer to question #3 is yes, what are the specific job functions in which you are unable to perform because of the physical or mental condition?

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5) If you listed job functions in item 4, what accommodation(s) do you request. Please describe how each such requested accommodation will enable you to perform such functions and/or meet performance standards?

a) ____

b) ____

c) ____

d) ____

Employee Signature ___________________________________ Date________________

To be completed by Human Resources Representative:

Date *Request for Reasonable Accommodation* form received by Human Resources: ______________________
Date *Request for Healthcare Provider Response form* received by Human Resources: _____________________
Date of interactive process meeting: ____