REQUEST FOR REASONABLE ACCOMMODATION

To the Employee/Applicant: To initiate this request, please complete this form and submit to the Equal Employment Opportunity Advisor, Office of General Counsel. Attach additional sheets as necessary.

Date of Request: ______________________

Name of Employee/Applicant: ____

Position Title: _________________________ Work Phone: ____________ Home Phone: ______________

Office/Work Location: ____

Reasonable accommodation needed for (check one):

( ) Application Process
( ) Performing job functions or accessing the work environment
( ) Accessing a benefit or privilege of employment (e.g., attending a training program or special event)

Describe your disability(ies) and how it/they affect(s) your ability to do your job? _____________________

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What is/are your requested accommodations? If accommodation is/are time-sensitive, please explain. Be as specific as possible (adaptive equipment, staff assistant, removal of architectural barrier, reader, interpreter, etc.)

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How will the requested accommodation be effective in allowing you to perform the essential functions of your job?

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Signature ____ Date ______________________

Name of Supervisor: ____

All requests for accommodation will be handled in a prompt and expeditious manner. All records of reasonable accommodation will be kept confidential.

Medical Inquiry Form to Support Accommodation Request

Form to be completed by Employee/Requestor's Health Care Provider after discussion with employee.

A. A person has a disability under the ADA if the person has an impairment that substantially limits one or more major life activities.

Does the employee have a physical or mental impairment? ( ) YES ( ) NO

If yes, what is the impairment? ____

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Is the impairment long term or permanent? If not permanent, how long will the impairment likely last? ____

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Does the impairment affect a major life activity? ( ) YES ( ) NO

If yes, what major life activity(ies) is/are affected?

( ) Caring for Self ( ) Walking ( ) Hearing ( ) Lifting
( ) Interacting with Others ( ) Standing ( ) Seeing ( ) Sleeping
( ) Performing Manual Tasks ( ) Reaching ( ) Speaking ( ) Working
( ) Bodily Functions ( ) Eating ( ) Reading ( ) Bending
( ) Breathing ( ) Thinking ( ) Learning
( ) Toileting ( ) Sitting ( ) Concentrating
( ) Other : (describe) ____

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Does the impairment affect the operation of a major bodily function? ( ) YES ( ) NO

If yes, what operation of a major bodily function is/are affected?

( ) Immune System ( ) Special Sense Organs and Skin ( ) Normal Cell Growth
( ) Digestive System ( ) Genitourinary ( ) Bladder ( ) Endocrine
( ) Neurological ( ) Brain ( ) Respiratory ( ) Circularly
( ) Cardiovascular ( ) Hemic ( ) Lymphatic ( ) Musculoskeletal
( ) Reproductive Functions ( ) Bowel ( ) Other: (describe)

Is the employee substantially limited in one of these major life activities? ( ) YES ( ) NO

B. An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability.

What disability(ies) is/are interfering with job performance? ____

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What job function(s) is/are the employee having trouble performing because of his/her disability(ies)?

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How does the employee's disability(ies) interfere with his/her ability to perform the job function(s)?

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C. If an employee has a disability and needs an accommodation because of the disability, the employer must provide a reasonable accommodation, unless the accommodation poses an undue hardship.

As the Health Care Provider, do you have any suggestions regarding possible accommodations to meet satisfactory job performance? If so, please describe. ________________________________

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How would your suggestions improve the employee's job performance? ________________

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D. Additional Comments:____

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Health Care Provider's Signature: ____

Address: ____

Phone Number: ____

Date: ________________________________

Return completed form in a sealed envelope, marked personal and confidential to:

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