Title II of the Americans with Disabilities Act (ADA) of 1990 requires employers to provide reasonable accommodations for qualified employees with disabilities. This form provides a standard written documentation of an employee’s request for reasonable accommodation and is to be submitted to the Affirmative Action, ADA/504 Officer. The form may be submitted via the Department Head/Supervisor or directly to the Affirmative Action, ADA/504 Officer. Completing this form is not a guarantee that the request will be granted. Approved accommodations are subject to annual review.

Request From: _______________________________ Date: __________________________

Position/Title: _______________________________ Office Ext: __________________________

Department: _______________________________ Supervisor: __________________________

Home Address: ________________________________________________________________

______________________________________________________________________________

Home Phone: __________________________ Cell Phone: __________________________

PLEASE BRIEFLY ANSWER QUESTIONS 1-5 BELOW: (Continued on page 2 of form).

1. What is your disability? What, if any, job function are you having difficulty performing?

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______________________________________________________________________________

______________________________________________________________________________

2. How does your disability impact your daily living outside of work?

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3. How does the disability impact your ability to perform your duties at work?

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4. Describe what you think will help you effectively perform your job and how that accommodation will assist you.

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______________________________________________________________________________

______________________________________________________________________________
5. Please list and attach your medical documentation, if available. Verification may be required.

To be completed by Department Head/Supervisor: Would the requested accommodation, if granted, fundamentally alter the position or impact any other employee’s job duties or position? Yes [ ] No [ ]
If yes, please explain and/or provide any other relevant information.

Signed: Department Head/Supervisor Date Print Name: Dept. Head/Supervisor
(The department supervisor is responsible for implementing the accommodation, subject to approval.)

Signature of Employee Print/Type Employee Name Date Reviewed by AA Officer

Action(s) taken:

A. Interactive Process – Meeting held with Requestor and supervisor -- union representatives may be present.

Date Initial Conference Date (if applicable) Initial

Outcome: __________________________________________________________

______________________________________________________________

B. Granted/Approved ____________________ C. Disapprove ____________________

Craig Wright, ADA/504 Officer Date

*Approved accommodations are subject to annual review, and may require resubmitting of medical documentation and/or update request form.