

Americans with Disabilities Act ACCOMMODATION REQUEST FORM

Employee Name: _____ Department: _____

Job Title: _____ Date the accommodation is needed: _____

Please provide the following information. Use additional pages or provide documentation as needed.

1. Explain the reason for which you are requesting the accommodation and estimated duration of the accommodation:

2. Explain how your stated reason impairs or limits your ability to perform assigned job duties:

3. What specific accommodation(s) are you requesting, if known?

4. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore or what has worked in the past? If yes, please explain or attach information.

5. Has a health care professional recommended a specific accommodation? If yes, please describe or attach documentation:

6. Please provide any additional information that might be useful in processing your accommodation request. We will set up a time to meet to discuss your request.

Signature

Date

Return this form to your supervisor or the Human Resources Department.