University of Houston Clear Lake

Request for Workplace Accommodation Form

(to be completed by employee)

Employee Name_____EmplID_____ Date _____

Job Title_____ Department _____ Ext._____

Type of Accommodation Requested

___ schedule change ___ work site modification ___ modification of duties ___ special equipment needed ___ job restructuring

___ interpreter/reader ___ modification of equipment ___other _____

Employee must provide a detailed description of each type of requested accommodation in the space below (attach a separate sheet, if necessary):

_____
_____
_____
_____
_____
_____
_____

Medical documentation to support accommodation request attached: ☐ Yes ☐ No

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I authorize the ADA Coordinator to contact and exchange information with my supervisor, my licensed health care practitioner and/or any other individual the ADA Coordinator deems appropriate, pertaining to my ability to perform my essential job functions, to work in the job environment, and to work a particular job schedule. Information exchanged will be limited to those individuals responsible to make and/or implement workplace accommodation determinations.

Employee Signature _____ Date _____

FINAL APPROVAL IS SUBJECT TO INSTITUTIONAL REVIEW

Original: ADA Coordinator

Copy: Employee's Supervisor