

## 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):

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Medical documentation to support accommodation request attached:  Yes  No

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