Americans with Disabilities Act
ACCOMMODATION REQUEST FORM

Employee Name:_____ Date: _____

Job Title:_____ Supervisor Name:_____

Please provide the following information & return the completed form to the Human Resources Department.

1. Identify your disability or physical or mental impairment(s) or limitation(s) ("Disability"):

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

3. Expected duration of the Disability:

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

5. If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? If *yes*, please explain or attach information.

6. Has a health care professional recommended a specific accommodation? Please describe or attach documentation:

7. Is your accommodation request time sensitive? If *yes*, please explain.

8. If you are requesting a specific accommodation(s), how will that accommodation(s) assist you to perform you job?

9. Have you had any accommodations in the past for this same limitation? If *yes*, what were they and how did the accommodation(s) help you perform your job?

10. 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