AMERICANS WITH DISABILITIES ACT EMPLOYEE REQUEST FOR ACCOMMODATION

Americans with Disabilities Act
Employee Request for Accommodation

This form may be completed when an employee is making a request for accommodation due to a documented disability. To be eligible for a reasonable accommodation under the Americans with Disabilities ACT (ADA), you must be qualified to perform the essential functions of your position with or without accommodation, and have a qualifying disability that limits a major life function.

Employee Name:	Employee Phone:
Supervisor:	Supervisor Phone:
Department:	Date:
1. Describe how your disability limits your ability to perform the essential functions of your job. Identify the essential functions affected and be specific about how the medical condition impairs your ability in each instance.	
2. Specifically describe the accommodation(s) you are proposing.	
3. Please add any comments you feel may be helpful in our consideration of your request.	

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By signing below, I authorize and give permission to Shawnee State University to obtain documentation and information from my physician and/or health care professional in regard to my request for reasonable accommodation(s). I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements.

I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.

*Print Name*___________________________________

Signature ____________________________________ Date ___________________________