ADA ACCOMMODATION REQUEST FORM

Date Request Submitted

Employee ID No.

Employee Name (First and Last Name)

Employee Email Address(s)

Position/Title

Campus/Work Location

Supervisor Name

Employee Phone Number(s)

Nature of Qualifying Disability (Please describe the nature and severity of the disability or potential harm and/or the likelihood that the potential harm will occur.)

Requested/Suggested Accommodation (Please describe the accommodations you believe are needed to enable you to perform the essential functions of your job.)

Physician Contact Information (Please provide name, address, telephone/fax number, and email address.)

****The ADA Request Review Committee will review and evaluate requests for accommodations and recommend appropriate accommodation(s) if it determines that the request meets the criteria established by the ADA. The committee will determine if you qualify as an individual with a disability and if it is feasible to provide accommodation(s). Due to delays that may be caused in communications with physicians, a specific decision date cannot be provided for physician review cases.****

ADA COORDINATOR COMPLETES BELOW INFORMATION

Date Request Received

Date Physician Statement Received

Date Met with Employee

Date ADA Review Committee met

Accommodation Timeframe

Follow-up Date

Rev. 08/2023

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