ADA: Request for Reasonable Accommodation Form

NAME: DATE:

WORK PHONE: HOME PHONE:

EMAIL:

POSITION: LOCATION:

DEPARTMENT: SUPERVISOR/PRINCIPAL:

NATURE OF THE QUALIFYING DISABILITY: (Please describe the nature, extent, and duration of your disability.)

REQUESTED/SUGGESTED ACCOMMODATION: (Please describe the accommodations you believe are needed to enable you to perform the essential functions of the job.)

PHYSICIAN CONTACT INFORMATION (Employees only) (Please provide name, address, telephone and fax numbers. The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations.)

I authorize the release of necessary confidential medical information regarding my disability to relevant hiring managers as deemed necessary by Human Resources. I also attest to the fact that a copy of the position description has been given to me for review and reference.

Signature: Date:

[To signatory: In non-physician review cases, decisions regarding accommodations will be made within 10 days of the receipt of this form by Human Resources. Due to delays that may be caused in communications with physicians, no special decision date can be provided for physician review cases.]