

Americans with Disabilities Act

Accommodation Request Form

Employee Name:

Location:

Job Title:

Employee ID No.:

Please provide the following information. Use additional pages or provide documentation as needed.

1. Identify your disability or physical or mental impairment(s) or limitation(s) ("Disability"):
2. Explain how your Disability impairs or limits you 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 made a specific recommendation? Please describe and or attach documentation:
7. If you are requesting a specific accommodation(s), how will that accommodation(s) assist you to perform your job?
8. Please provide any additional information that might be useful in processing your accommodation request.

Signature:

Date:

Return this form to your Human Resources Department and/or Manager