ADA EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM

Date: ______________________

Employee's Name: ____

Phone: ______________________ **Email:** ______________________

Job title: _____________________ **Program**:: __________________

Supervisor's name: ____

Describe the nature, extent and duration of your disability:

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Describe the accommodations you believe are needed to enable you to perform the essential functions of this job:

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Provide the name, address, telephone and fax numbers of your health care provider. The provider may receive a request from us for information regarding your impairment/disability and recommendations for accommodations.

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Attach any supporting documentation that may be helpful in evaluating this request for accommodation.

I authorize the release of information regarding my disability to [Company name} management as deemed necessary by human resources to facilitate this request for accommodation.

Employee signature: ____
Date: ____