



ACCOMMODATION REQUEST FORM

1. What specific accommodation are you requesting?

2. Is your accommodation request time sensitive?

Yes

No

If yes, please explain.

3. Is this for a limited time?

Yes

No

If yes, for how long? If no, please explain.

4. What job function are you having difficulty performing, if any, based on your position description and/or daily job responsibilities?

5. What limitation (major life function) is interfering with your ability to perform your job (i.e., walking, breathing)?

6. Have you had any accommodations in the past? Yes No

If yes, what were they? How effective were they? Why did the accommodations end? Was it for the same limitation?

7. Has your limitation been diagnosed by a Physician? Yes No

If yes, please provide contact information for your Physician (name, address, telephone number). You may attach official documentation from your Physician concerning your limitation.

Please provide any additional information that might be useful in processing your accommodation request:

Signature

Date