



REQUEST FOR ACCOMMODATION

The purpose of this form is to document your request for reasonable accommodation to enable you to perform the essential functions of your job. In order to evaluate your request, we will need information regarding your disability, your functional limitations and your requested accommodation(s). Please complete and return the original form to the Director of Human Resources or the Assistant to the President for Equity Programs.

General Information

_____	_____	_____
Name (Last)	(First)	(MI)
_____	_____	_____
Job Title		Work Telephone Number
_____		_____
Department/Division		Home Telephone Number

Disability and Accommodation Information

Describe the nature of your disability and the impact on your performance of the essential functions of your job, as outlined in your position description: _____

Specify the nature of your requested accommodation(s), including any equipment, aids or services: _____

Submit current professional evidence to the Office of Human Resources documenting the disabling condition and verifying need for the requested accommodation. This information will be treated as a confidential medical record and used solely for the purpose of discussing your need for accommodation. After you have returned this form to the Office of Human Resources, we will schedule a meeting to discuss your request. Please note that all medical/diagnostic information is kept separate from your personnel file and is filed in a confidential limited access file.

A determination regarding your request will be made within (30) thirty working days of receipt of this form. If you wish to appeal the determination, you may file a complaint through the College discrimination complaint procedure.

Employee Signature _____ Date _____