



**Employee Request for Accommodation Form  
-Confidential-**

Applicant or Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Position or Title: \_\_\_\_\_

Department/Supervisor: \_\_\_\_\_

**Applicant or Employee** – Please complete this section, and return the completed form to the Human Resources department. Request is confidential and will only be shared with those who have a right to know.

Identify your condition(s) and indicate how you believe each condition affects your ability to perform the essential duties of the position:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State the requested accommodation(s) and any alternatives:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Human Resources Use Only**

Date Received: \_\_\_\_\_ Date(s) Reviewed: \_\_\_\_\_

Accommodation approved or denied: \_\_\_\_\_

Request for Appeal: Yes No

Date Received: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

**Summary of outcome (attach any supporting documents)**

\_\_\_\_\_  
Signature of ADA Coordinator or designee

\_\_\_\_\_  
Date