AMERICANS WITH DISABILITIES ACT

EMPLOYEE REQUEST FOR ACCOMMODATIONS

Employee Name Job Title

Supervisor's Name Phone Number

Please describe the medical condition for which you are requesting an accommodation, including what major life activities are impacted by the condition.

Please explain how the medical condition affects your ability to perform your job.

Please describe the reasonable accommodations you are requesting.

I understand that my request for accommodations will require medical documentation, and that it is my obligation to supply such documentation. I further understand I may be required to execute a release authorizing my health care provider to disclose my medical records and discuss my disability and treatment. I further understand that my failure to provide the required medical documentation and/or release may result in the College's inability to approved my requested accommodation. I have received a copy of the Guide for Requesting Accommodations for Employees and Prospective Employees with Disabilities. I understand that my medical condition will be kept confidential to the extent possible but that it can be disclosed as explained in the Guide.

_____ _____

Employee Signature Date