

(ADA-99)
EMPLOYEE REQUEST FOR ACCOMMODATION UNDER
THE AMERICANS WITH DISABILITIES ACT (ADA)

Employee Requesting Accommodation: _____

Position/Title: _____

Department/School: _____

Work Address: _____

Work Telephone Number: _____ Home Number: _____

Immediate Supervisor: _____ Phone Number: _____

ACCOMMODATION BEING REQUESTED: (use back to continue, if necessary)

REASON FOR ACCOMMODATION (identify condition and functional limitation(s) for which you seek an accommodation):
Condition: _____

Functional limitation(s): _____

INSTRUCTIONS FOR EMPLOYEE

PLEASE ATTACH OR PROMPTLY PROVIDE DOCUMENTATION FROM AN APPROPRIATE HEALTH CARE PROVIDER DESCRIBING YOUR FUNCTIONAL LIMITATIONS AND SPECIFYING THE MEDICAL CONDITION CAUSING THE FUNCTIONAL LIMITATIONS.

Employee Signature: _____ **Date:** _____

cc: ADA Coordinator