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Employee Accommodation Request Form EXAMPLE

A Note to the Employee Filling Out this Form

The information collected below is intended to facilitate the interactive process (ongoing informal and flexible conversations between the employee and employer) when an employee, or someone acting on their behalf, makes the employer aware of the need for a reasonable accommodation(s).

In order to have Americans with Disabilities Act (ADA) rights, a person must have a disability as defined by the law. Reasonable accommodations are meant to remove workplace barriers as it relates to a disability/medical condition in order to create equal opportunity.

A workplace barrier is created when a person's disability/medical condition manifestations or symptoms effect the job's essential function(s) or an employment benefit(s), resulting in limitations to do the essential function(s) or enjoy a workplace benefit(s).

You don't necessarily have to have specific accommodation suggestions. You do have the obligation to indicate a need for a work adjustment due to a disability/medical condition and to fully participate in the interactive process to attain appropriate reasonable accommodation solutions.

The ADA allows an employer to learn from an appropriate professional* the following when the disability/medical condition or the need for the accommodation is **not known and/or obvious**.

- Does the employee have a substantial limitation in one or more major activities or has a record of such an impairment.
- What is the duration of the impairment?
- What specific disability symptoms/manifestations are involved regarding the workplace?
- What essential functions or workplace benefits are involved?
- What are the particular barriers that are created?
- What appropriate barrier removal (reasonable accommodation) suggested solutions can be implemented?

If a leave of absence as a reasonable accommodation is required, the employer can inquire if it will be continuous and/or intermittent and for an estimate of how long leave will be needed.

*Please note that medical documentation is only one piece of information that will be factored in to assessing appropriate reasonable accommodations.

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Employee Accommodation Request

EMPLOYEE NAME _____

JOB TITLE/CLASSIFICATION _____

DEPT/DIVISION _____ PHONE _____

EMAIL ADDRESS _____

WORK LOCATION _____

SUPERVISOR'S NAME _____

SUPERVISOR'S PHONE _____

WORK SCHEDULE (DAYS AND HOURS)

WORK LOCATION

(If you need more room to answer any questions or requests below, please use the back of this sheet or add additional sheets)

Identify your disability/medical condition as it solely relates to limiting your ability to do your job and/or enjoy workplace benefits.

What job functions or benefits of employment are you having trouble performing or accessing when your disability/medical condition limitation(s) manifest concerning your employment?

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If you do have a specific accommodation request(s), please describe your request(s) in detail.

If you have a specific reasonable accommodation(s) request, describe how you believe the requested accommodation(s) will enable you to perform the essential functions of your job and/or access benefits of employment.

Please provide any other information as it pertains to your disability/medical condition as it only applies to the workplace which might help evaluate your request.

I give _____, permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA).

By signing below, I further authorize and give permission to _____ secure documentation and information from an appropriate health care professional regarding my request for reasonable accommodations as it pertains to functional limitations in performing my essential job functions or accessing benefits of employment.

I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements and the Health Insurance Portability Accountability Act of 1996 (HIPPA).

I further understand that I will be required, in as timely a manner as possible, to provide appropriate documentation of information regarding the manifestations or symptoms of my disability/medical condition which effect my job’s essential function(s) or employment benefits if my condition and/or need for reasonable accommodation is not obvious.

Signature _____ Date _____

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