

ADA Reasonable Accommodation Request Form

Date: _____

Employee's Name: _____

Phone: _____ Email: _____

Job title: _____ Department: _____

Supervisor's name: _____

Describe the nature, extent and duration of your disability:

Describe the accommodations you believe are needed to enable you to perform the essential functions of this job:

Provide the name, address, telephone and fax numbers of your health care provider. The provider may receive a request from us for information regarding your impairment/disability and recommendations for accommodations.

Attach any supporting documentation that may be helpful in evaluating this request for accommodation.

I authorize the release of information regarding my disability to [Company name] management as deemed necessary by human resources to facilitate this request for accommodation.

Employee signature: _____

Date: _____