

# Employee Request for Reasonable Accommodation Form

This form is used by employees to request a reasonable accommodation under the Americans with Disabilities Act (ADA) or other applicable laws. Please complete this form and return it to the Human Resources department.

## Employee Information

Employee Full Name:

Job Title:

Department / Division:

Supervisor Name:

Phone Number:

Email Address:

Date of Request:

## Accommodation Request Details

1. Identify the physical or mental impairment(s) and the limitation(s) impacting your ability to perform your job functions:

2. Describe the specific accommodation(s) you are requesting (e.g., specific equipment, schedule change, physical modification):

3. Explain how the requested accommodation will assist you in performing the essential functions of your job:

4. What is the expected duration of the accommodation? (e.g., temporary until [Date], permanent):

## Medical Documentation

Medical Provider Name / Contact Information (if supporting documentation is attached):

## Signatures and Authorization

By signing below, I certify that the information provided on this form is true and accurate to the best of my knowledge. I understand that additional medical documentation may be required to process this request.

Employee Signature:

Signature Date: