Employee Accommodation Request Form

This form must be completed by the employee when making a request for accommodation due to a documented disability covered by the Americans with Disabilities Act (ADA). To be eligible for a reasonable accommodation under the ADA, employees must be qualified to perform the essential functions of their position with or without an accommodation, and have a qualifying disability that substantially limits a major life activity.

Employee Name: _____________________________      CWID: ________________________________
Job Title: ___________________________________     Work Phone: ___________________________
Department: ________________________________        Work Location: __________________________
Supervisor Name: ____________________________          Supervisor Phone: _______________________
Work Schedule: (Days & Hours) ________________________________

1. Please describe the physical, mental, or cognitive impairment(s) which you claim limits your ability to fully perform your job.

2. Is your impairment temporary or permanent? If temporary, how long do you expect to be impaired?

3. Please describe what specific parts of your job you are unable to fully perform because of your impairment. Include the essential functions that cannot be fully performed, and/or job-related limitations.

4. Describe the accommodations you are requesting. Be as specific as possible (i.e., if you are requesting a piece of equipment or a device, please provide description, manufacturer, cost, where to order, etc.).

5. Describe how the requested accommodations will enable you to perform those aspects of your job that you cannot fully perform due to the impairment.
6. Please provide any other information that might help The University of Alabama evaluate your request.

I have voluntarily completed this Employee Accommodation Request Form and all information provided is complete, true, accurate, and not misleading. I give The University of Alabama permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate University personnel and/or my health care professional, and acknowledge that such communication is job-related and consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I may be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.

Signature: _______________________________ Date: __________________

Return Completed Form to:
The University of Alabama
Attn: Emily Marbutt, HR ADA Coordinator
Box 870364
Tuscaloosa, AL 35487
205-348-8755 (fax)

Contact Information:
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