UNIVERSITY HUMAN RESOURCES

Employee Accommodation Request Form

This form is an initial step in processing your request for an accommodation under the Americans with Disabilities Act (ADA). An accommodation is a reasonable modification or adjustment to the work environment that enables a qualified person with a disability to perform the essential functions of a position, or enjoy the same benefits and privileges of employment as are enjoyed by non-disabled employees. In order to determine whether you are eligible for an accommodation under the ADA, the ADA Coordinator will ask for documentation of your disability.

The ADA requires that the ADA Coordinator keep medical information confidential. However, the law allows the ADA Coordinator to share information regarding your disability with individuals who are considered to have a legitimate need to know this information. These persons can include your supervisor(s), human resources personnel, first aid and safety personnel, personnel investigating compliance with the ADA, and other persons considered to have a legitimate need to know.

EMPLOYEE INFORMATION	
Date Requested:	Department:
Employee Name:	Position:
Email Address:	Supervisor:
Phone/Ext:	Supervisor’s Phone:
Department HR Representative:	

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ACCOMMODATION REQUEST DETAILS

Please describe the disability for which you are requesting an accommodation:

Please describe in detail how your disability affects your ability to perform your job responsibilities:

Please describe the reasonable accommodation(s) you are requesting and how the accommodation(s) will aid you in performing your duties:

Employee Name (printed) Signature Date

3110 Chesapeake Building
College Park, MD 20742

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RELEASE OF INFORMATION

I authorize my treatment provider(s) to release information to, and if necessary, speak with the University of Maryland College Park ADA Coordinator(s) about my disability as listed above for the purpose of determining appropriate and reasonable employment accommodation(s).

Employee Name (printed) Signature Date

Please submit the complete form via email to Christine Hottel at **chottel@umd.edu**, by fax to 301-405-5885, mail or in person to:

Christine Hottel
University of Maryland Office of Staff Relations
3110 Chesapeake Building
4300 Terrapin Trail
College Park, MD 20742
301.405.2182

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ADA Disability Information Request Form
(To be completed by Medical Provider)

Employee Name: ________________________ **Date of Birth:** ______________

The University of Maryland College Park employee named above has requested that the University provide him/her with a reasonable accommodation under the Americans with Disabilities Act (ADA). Under the ADA an individual with a disability is a person with a physical or mental impairment that substantially limits one or more major life activities, such as breathing, eating, sleeping, walking, talking, seeing etc. An employee making such a request must provide the University with current documentation of a disability. You are being asked by the employee to provide documentation by fully completing all sections of this form. These questions will help determine 1) whether the employee has a disability, 2) whether an accommodation is needed, and 3) what options may exist that would constitute an effective, reasonable accommodation. Also, please provide any supplemental material that you feel would be helpful in considering the employee's request for accommodation(s)

This form may be returned to the employee or it may be mailed or faxed to:

Christine Hottel
University of Maryland Office of Staff Relations
3110 Chesapeake Building
4300 Terrapin Trail
College Park, MD 20742
301.405.2182
Fax: 301.405.5885

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1. **Please identify this individual's physical or mental impairment(s):**

2. **Please describe the effects or limitations this impairment has on the individual's major life activities, if any:**

3. **Please describe whether the effects or limitations are long-term, permanent, or short-term.**

4. **How does the individual's limitation(s) interfere with his or her ability to perform the responsibilities assigned to them as an employee?**

5. **Are there any activities or job functions that would present a health or safety risk to the individual or others due to the impairment or its treatment?**

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6. Please provide suggestions for possible accommodations that will enable the employee to perform their essential responsibilities.

____

Signature of physician or care provider   Date

____

Provider name (printed)   Telephone#

____

Provider Address/City/State/Zip