ACCOMMODATION REQUEST FORM

The University of South Florida is committed to equal opportunity in all aspects of employment. This form is intended to assist in determining whether, and to what extent, a reasonable accommodation is necessary and available for an employee with a disability to perform the essential functions of his or her job safely and effectively. The information you provide will be kept confidential consistent with state and federal laws. Information may be shared with supervisors and managers to the extent necessary to engage in the interactive process regarding necessary accommodations. Health and safety personnel may be informed if the condition might require emergency treatment. Government and University officials investigating compliance with applicable laws might be informed on the information disclosed.

EMPLOYEE INFORMATION:

Name: ___________________________________________  Department: __________________________

Position/Title: ________________________________  EMPLOYEE #__________________________

Work telephone #: ____________  Other contact #: ________________________________

Email address: ____________________________________________________________

Immediate Supervisor: ____________________________________________

Current work schedule/shift/days worked:

____________________________________________________________________

Is your position: _____ Full-time    _____ Part-time

University official(s) contacted about accommodation:

________________________________________________________________________

DISABILITY INFORMATION:

1. Please indicate the nature of your disability:\

   _____ Visual       _____ Respiratory       _____ Mental/Psychological
   _____ Hearing      _____ Speech           _____ Learning Disability
   _____ Mobility     _____ Neurological     _____ Other (please specify)

\[In general, for purposes of this form the term “disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual.\]
2. Is your disability:
   ___ Temporary  (If so, how long?) ________________________________
   ___ Permanent

3. Please briefly explain any limitations or restrictions caused by your disability:
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

4. Please list any accommodation(s) or service(s) related to your disability that would help you meet the essential functions of your current job:
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

I hereby agree that the Division of Human Resources can share relevant information from my physician or other health care provider(s) with the supervisor(s) in my immediate work unit and with other University offices that may be involved in assisting in the development of reasonable accommodations to assist me in completing my assigned work responsibilities.

The Division of Human Resources also has my permission to contact my physician or other health care provider(s) for additional information to assist in developing reasonable accommodations for me.

I understand that I must also submit the “ADA Interactive Process Health Care Provider Questionnaire” form signed by an authorized physician or other health care provider. This form
should include a description of my disability; any related limitations; and recommendations for accommodation(s) and/or service(s).

________________________________________  ______________________
Employee Name  (Print)  Date

________________________________________
Employee Signature