



**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<sup>1</sup>:

- |                                   |                                       |   |
|-----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Visual   | <input type="checkbox"/> Respiratory  | <input type="checkbox"/> Mental/Psychological   |
| <input type="checkbox"/> Hearing  | <input type="checkbox"/> Speech       | <input type="checkbox"/> Learning Disability    |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Neurological | <input type="checkbox"/> Other (please specify) |

<sup>1</sup> 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

Please return the completed form to the Division of Human Resources by:

- Fax: 813-974-5227
- Email: [HR-ADA-Request@usf.edu](mailto:HR-ADA-Request@usf.edu)
- Mail/hand delivery:  
University of South Florida  
Division of Human Resources ADA  
4202 E. Fowler Avenue  
Tampa, FL 33620