

## Americans With Disabilities Act (ADA) Request for Reasonable Accommodation

APPLICANT INFORMATION  
*(Attach supporting medical documentation)*

Staff <input type="checkbox"/>	Faculty <input type="checkbox"/>	Student <input type="checkbox"/>
Employee Name:	Email:	Employee ID:
Department:	Supervisor:	Supervisor Phone:

### DISABILITY REQUIRING ACCOMMODATION

**Accommodation Requested** (Check box below):

Adjustment or Modification of Examination/Training <input type="checkbox"/>	Facilities <input type="checkbox"/>	Reassignment <input type="checkbox"/>	Materials or Policies <input type="checkbox"/>	Temporary Job Restructuring <input type="checkbox"/>
Modifying Equipment or Devices <input type="checkbox"/>	Part-time or Modified Work Schedule <input type="checkbox"/>	Parking <input type="checkbox"/>	Readers or Interpreters <input type="checkbox"/>	Other <input type="checkbox"/>

**Please describe the physical, mental or cognitive impairment(s) which limits your ability to perform the essential functions of your job.**


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


**Describe how your condition limits your ability to perform the essential functions of your job.**


**Describe the accommodation(s) 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, if known)**


**Describe how the requested accommodation(s) will enable you to perform the essential functions of your job.**


**Please describe any other information that might help Sweet Briar College evaluate your request.**


I have voluntarily completed this Employee Accommodation Request Form and all information provided is true and accurate. I give Sweet Briar College 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.

<b>Employee Signature:</b>	<b>Date:</b>
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**Employee Accommodation Request Form**  
**Request for Reasonable Accommodation**

AREA BELOW FOR OFFICE USE ONLY

Request Granted

From (date):

To (date):

Request Denied (*Please state reason for denial*)

**Notes and/or Description of Accommodations:**

*(If cost exceeds \$500, approval of VP of Finance and Administration is required)*

Signatures

Human Resources:

Date:

VP of Finance and Administration:

Date: