

**REOUEST FOR REASONABLE ACCOMMODATION
OF EMPLOYEE WITH DISABILITY**

*PLEASE PRINT

Assistive Equipment ____ (Estimated Cost) _____ Job Modification ____

Last Name First Name M.I.

Address Apt. City State Zip Code

University Telephone #: _____ Email Address: _____

Department: _____ Room: _____

Please circle one: Faculty Administrative Staff Temporary Other

Employee Title: _____

Name & Telephone of Direct Supervisor(s): _____ / _____

Gender: Male ____ Female ____

Currently registered with EOP? Yes __ Date _____ No __

If registered, what type of disability (ies)?

Indicate present disability (ies) by circling the following:

Hearing Speech Learning Physical Visual Other

If other, please specify: _____

Are you presently receiving an accommodation(s)? Yes ____ No ____

If yes, please indicate who provided the accommodation, describe the type of accommodation, and the date granted: _____

Are you presently under a physician's care? Yes ____ No ____

If yes, name and contact information of physician: _____

Emergency Contact:

Name Relationship Telephone #