

St. Cloud State University
Employee Request for ADA Reasonable Accommodation

Employee Name: _____ Date: _____

Job Title: _____ Department: _____

This information will be used by Human Resources and any other person who is authorized by my employer to handle medical information for ADA purposes and, any information concerning my physical or mental condition, that is necessary to determine whether I have a disability as defined by the American with Disabilities Act, and to determine whether any reasonable accommodations can be made. The provision of this information is voluntary, however if you refuse to provide it, your employer may refuse to provide reasonable accommodation.

1. Please describe the nature of your limitations, what life activity(s) it substantially limits, and how this life activity is substantially limited.

2. How does it affect your ability to perform your job?

3. Type of accommodation you are requesting:

Making facilities readily accessible

Job restructuring

Part time or modified work schedule

Modification to a rule, policy or practice

Modification of equipment or devices

Qualified reader or interpreter

Acquisition of equipment or devices

Other: _____

Please describe in detail the accommodation you are requesting:

4. How will the requested accommodation be effective in allowing you to perform the essential functions of your job?

5. Additional comments:

Signature of Employee

Date