ALLEGHENY COLLEGE

REQUEST FOR ACCOMMODATION

This section is to be completed by the Employee

The purpose of this form is to document your request for reasonable accommodation to enable you to perform the essential functions of your job. In order to evaluate your request, please complete this form to provide information regarding your disability, functional limitations and requested accommodation(s). This form should be returned to the Office of Human Resources.

General Information

_____ _____

Employee Name (Last) (First) (MI) Social Security Number

_____ _____

Job Title Department

Disability and Accommodation Information

Describe the nature of your disability:

Specify your functional limitations with respect to your disability:

Specify the nature of your requested accommodation(s), including any equipment, aids or services:

Please have your treating health care provider complete the Health Care Provider section of this form.

Employee Signature _____ Date _____

_____

Employee Name (Last) (First) (MI)

This section is to be completed by the Health Care Provider

Dear Health Care Provider,

A request for an employment-related reasonable accommodation has been made by the above named employee. Your assistance with this process is appreciated. Please complete the following questions below and return the form to: Allegheny College, Office of Human Resources, 520 N. Main Street, Meadville, PA 16335.

1) Please review the attached job description. (If no job description is attached, please discuss the position with the employee.) Is the employee able to perform the essential job functions of this position with or without reasonable accommodation? Yes / No

If *yes*, please continue to next question. If *no*, how long will the employee be unable to perform these job duties?

____ # of weeks ____# of months ____ permanently

2) Does the employee have a physical or mental impairment? If *yes*, what is the impairment?

3) What adjustments to the work environment, position responsibilities, work schedule, etc. would enable the employee to perform the essential functions of that position?

4) How long will the employee need the accommodation?

Any additional comments or suggestions:

Provider Signature _____ Date _____

Provider Name (Please Print) _____