

## ADA Reasonable Accommodation Request Form for Employees

Stockton University provides reasonable accommodations to qualified employees with disabilities. In general, it is the employee's responsibility to inform the supervisor of a need for a disability-related accommodation to perform the essential functions of the job held. Reasonable accommodations are determined, identified and implemented through an interactive process, a collaborative process involving the employee, supervisor, and the K ((] } ( , μ u v Z • } μ CE •.

An employee's disability is documented by the medical provider. Medical provider documentation for an employee's disability is sent to t

INFORMATION ABOUT YOUR ACCOMMODATION REQUEST

1. What is the medical diagnosis for which you are requesting the accommodation?
2. Does your condition limit any major life activity? If so, please explain which life activity/activities is/are affected.
3. Is your condition temporary or permanent (chronic)? If temporary, please indicate the duration of the condition.
4. Please list the accommodation(s) you are requesting.
5. If the requested accommodation(s) you listed cannot be provided in question 4, what other accommodation(s) might be responsive to your request?
6. How long do you anticipate the need for the requested accommodation?
7. Explain how the requested accommodation will enable you to perform the essential functions of your job.

ADDITIONAL INFORMATION

Are you currently on Short Term Disability?	Yes	No
Have you been approved for FMLA?	Yes	No
Have you been approved for a work modification by the Office of Human Resources?	Yes	No

Have you previously requested an accommodation at Stockton?      Yes                      No

If "Yes," is it the same condition or impairment that you are currently requesting an accommodation for?

If "Yes," approximately when was the request made? \_\_\_\_\_

I acknowledge that I am requesting an accommodation for a documented medical condition that substantially limits my ability to perform the essential function(s) of my current position. I agree to fully cooperate with the Office of , μ u v Z • }ip Esponding to my request, including providing the appropriate medical documentation. I understand that I may not be provided with the specific accommodation that I have requested; however, I understand that good faith efforts will be made in the decision process. I verify that the above information is complete and accurate to the best of my knowledge.

Signature: \_\_\_\_\_