Dear Employee:

To initiate a request for reasonable accommodation, please complete this form and forward to Tami Hannon via mail at The University of Akron, ADA Coordinator, Akron, OH 44325-4709 or via secure fax at (330) 972-5816. Should you have any questions, please call (330) 972-7300.

EMPLOYEE INFORMATION:	
Name:	Employee ID:
Classification/Title:	Work Phone:
College/Division:	Supervisor:
Department:	Work Location:
Work Schedule (Days & Hours):	

ACCOMMODATION REQUEST INFORMATION (Please attach additional sheets as necessary.)**:**
1. Describe the disability that impacts the performance of your job.
2. How does this disability affect your job?
3. What is your recommended accommodation? (Please include alternatives.)

I agree to provide any further information or documentation as may be needed to evaluate my request, and I authorize a release of my medical information.

Signature:_____ Date: _____

To the Employee:

To initiate a reasonable accommodation request, please sign the Release of Information below and have your physician or medical provider send the completed form directly to Tami Hannon, The University of Akron, ADA Coordinator, Akron, OH 44325-4709.

RELEASE OF INFORMATION:

I, , hereby authorize the release of the following information to The University of Akron for the purpose of determining reasonable accommodation(s).

Employee Signature:_____ Date: _____

To the Diagnosing Professional:

To ensure reasonable and appropriate accommodations, employees must provide current documentation of the disability. The American with Disabilities Act defines a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. As the diagnosing professional, you are asked to complete all sections of this form. Additional reports or information can be attached if necessary. Thank you for your assistance.

I. DIAGNOSIS: Please attach test results, e.g., an eye report with visual acuity and fields, audiology report, PT/OT evaluation, neuropsychological report, etc., and any additional sheets as necessary.	
Primary Diagnosis:	Date of Diagnosis:
History of Illness:	
Describe the nature and severity of the impairment:	
Is the condition persistent and long-term?	
If temporary, what is the expected duration?	

II. MEDICATION AND/OR CORRECTIVE MEASURES:
Describe whether medication and/or corrective measures that may correct the impairment have been prescribed (e.g., medication lowers high blood pressure to acceptable level; or corrective lenses improve vision to 20/40).

III. SUSTANTIAL FUNCTIONAL LIMITATIONS:
How does the impairment affect the employee in the activities required in the workplace? Does the condition interfere with the employee's ***major life activities***, and to what extent (e.g., breathing, caring for self, hearing, learning, performing manual tasks, seeing, speaking, walking, working, or other)?

Major Life Activities:

Substantial Functional Limitation(s):

IV. RECOMMENDED ACCOMMODATIONS:
Please list your recommended accommodations (e.g., accessible buildings, alternate format materials such as large print, Braille, assistive technology, or other).

If the recommended accommodation is time off from work, how much leave is recommended?

Are there any activities or situations that should be avoided or that would present a significant risk of serious injury or death for the employee?

Thank you for your assistance in provided this information so that we may provide services as soon as possible. Please attach your business card or other form of identification and return this document to:

Tami Hannon, The University of Akron
ADA Coordinator, Akron, OH 44325-4709
Or via secure fax at (330) 972-5816

Certifying Qualified Medical Provider Name and License Number: _____

Degrees/Title: _____ Phone: _____

Business Address: _____

Email: _____

Signature: _____ Date: _____