The University of Akron
ADA Coordinator's Office

Request for Reasonable Accommodation

To the Employee:

To initiate this request, please complete this form and forward to: Becky Hoover, (330) 972-6462 **or** Mark Stasitis, (330) 972-2352, The University of Akron, ADA Coordinator's Office, Akron , Ohio 44325-4733 **or** Fax to: (330) 972-2323.

Employee Information:

Name: ____ Employee ID: ________________________

Classification/Title: _____________________________ Work Phone: _________________________

College/Division: _______________________________ Department: __________________________

Supervisor: ___________________________

Work Schedule (Days & Hours): ____

Work Location: ____

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: ________________________________

(Please continue with the *Documentation of Disability* Form.)

HRF005 Revised 5/11/11

University of Akron
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Documentation of Disability

To the Employee:

To initiate this request, sign the Release of Information below and have your physician or medical provider send this form directly to Becky J. Hoover **or** Mark Stasitis, The University of Akron, ADA Coordinator's Office, Akron, Ohio 44325-4733.

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).

Signature: ______________________________________ Date: _______________________________

To the Diagnosing Professional:

To ensure reasonable and appropriate accommodations, employees must provide current documentation of the disability. The Americans 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. Substantial 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)?

Diagnosis/Condition(s): ____

____

Major Life Activity(ies): ____

____

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 requested 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 providing this information so that we may provide services as soon as possible. Please attach your business card or other form of identification and send this document to:

Becky Hoover, (330) 972-6462 or
Mark Stasitis, (330) 972-2352
The University of Akron, Akron, Ohio 44325-4733
Fax (330) 972-2323

Certifying Qualified Medical Provider/License Number: ______________________________________

Name/Degrees/Title: ____Phone: __________

Business Address: ____

Email: ____

Signature: ____________________________________ **Date:** ___________________________