



The University of Akron
AA/EEO Office

Request for Reasonable Accommodation

To the Employee:

To initiate this request, please complete this form and forward to Becky Hoover, ADA Coordinator, The University of Akron, Akron, Ohio 44325-4733. Telephone (330) 972-6462; Fax (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: _____



**The University of Akron
AA/EEO Office**

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, ADA Coordinator, The University of Akron, 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 accommodations.

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

Definition: Employee is *significantly* restricted in comparison to the average person in the general population as to the conditions, manner, or duration under which activities can be performed.

How does the impairment, in its corrected or medicated condition, 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, ADA Coordinator, The University of Akron, Akron, Ohio 44325-4733
Telephone (330) 972-6462 Fax (330) 972-2323

Certifying Qualified Medical Provider/License Number: _____

Name/Degrees/Title: _____ Phone: _____

Business Address: _____

Email: _____

Signature: _____ **Date:** _____