Western Illinois University
OFFICE OF EQUAL OPPORTUNITY AND ACCESS

DISABILITY DOCUMENTATION AND ACCOMMODATION REQUEST FORM

1 University Circle
Sherman Hall Room 203
Macomb, IL 61455

Phone: 309.298.1977
TTY: 309.298.2565
Fax: 309.298.3445

Part A: Employee Declaration of Disability and Request for Accommodation

In order that the Office of Equal Opportunity and Access may properly evaluate my request for reasonable accommodation, I,_____ , am providing clinical documentation
(Please print)
of my disability as completed by my treating physician.

Signature_____ Date_____

Part B: Employee Authorization for Medical Release

I, _____, authorize my treating physician, _____, to
(Please print) (Please print)
release to the ADA Coordinator at Western Illinois University, any and all information which shall be required with respect to my disability and the accommodation(s) being requested.

I understand that: 1) this form, and the information contained on it, will be kept separate from my personnel file and will be kept confidential; 2) this authorization will expire on the day my employment at Western Illinois University expires; 3) that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on this authorization; 4) the ADA Coordinator may assign my accommodation request to his/her designee within the office and that the ADA Coordinator or his/her designee may contact my physician to follow-up on or clarify the information provided.

I give this authorization voluntarily and with full understanding that it will be used in consideration of my accommodation request.

Signature_____ Date_____

Part C: Disability Certification **(To be completed by treating physician, psychologist, audiologist or psychiatrist)**

1. What is the covered disability for which accommodation(s) is/are being requested?

2. What major life activity is significantly limited by the disability? Please describe the limitations.

See Reverse Side

3. Please explain how the employee's disability impacts his/her ability to perform the essential functions of his/her job. (A copy of the job description should be provided by the employee)

4. If the employee's disability prevents him/her from performing any of the essential functions of his/her position, please identify any suggested accommodations that could be made to assist the employee in performing these functions.

5. Please provide any additional information that you believe to be relevant for our evaluation of this employee's request for reasonable accommodations.

Physician's Name (Please print) _____

Signature _____

State _____

Address _____

City _____ State _____ Zip _____

Phone _____

Please return this form to:

Office of Equal Opportunity and Access
Sherman Hall Room 203
Western Illinois University
Macomb, IL 61455

Or by Fax to: 309.298.3445

If you have any questions, please feel free to contact the Office of Equal Opportunity and Access at 309.298.1977.