Western Illinois University

EMPLOYEE REQUEST FOR REASONABLE ACCOMMODATION/AUTHORIZATION FORM

PART A: **Employee Information**: This form is completed by an employee or faculty who is requesting accommodation(s) for performing essential job duties. Sign and forward the completed form to the Office of Equal Opportunity and Access (EOA) and Office of Human Resources (OHR) for review and approval.

Employee Name/Title:	**Employee Type:** ____ **Admin Professional** ____ **Civil Service** ____ **Faculty**
Campus: ____ **Macomb** ____**Quad Cities**	**Department and Building**:
Phone Number:	**Email**:

PART B: **Declaration of Disability and Request for Accommodation**:
In accordance with the Americans with Disabilities Act, as amended, an employee with a disability has an impairment that substantially limits one or more major life activities or has a record of such an impairment. The information you provide will be used in discussions with the Office of Equal Opportunity and Access and Human Resources to determine if a reasonable accommodation will assist you to complete the essential job duties assigned to your position. Your treating health care provider may need to complete the ADA Medical Certification Form as advised by EOA and OHR. You may include attachments as needed.

Describe your physical or mental impairment(s)	
How do/does the impairment(s) interfere with your completion of essential job duties or your ability to participate in other privileges of employment?	
What accommodation(s) are you requesting?	
How will the accommodation(s) assist you to complete your essential job duties?	

PART C: Employee Authorization for Medical Release:

- I authorize my treating health care provider to release to the EOA office or Human Resource at Western Illinois University, information which shall be required with respect to my disability and the accommodation(s) being requested. The University representatives may contact my physician to follow-up on or clarify the information provided.
- I acknowledge that my treating health care provider may need to complete the ADA Medical Certification Form as requested by the Equal Opportunity and Access (EOA) or Human Resources specific only to my request for job accommodation(s).
- This information will be reviewed by EOA/HR and maintained in a confidential and secured location.
- Managers and supervisors may receive instructions related to the final determination on a need-to-know basis only.
- My signature below certifies that the information I've provided is a truthful and accurate request for an ADA accommodation.

Employee Signature	**Date** (Month/Date/Year)