ADA Request for Accommodation Form

Privacy Notice: State law requires that you be informed that you are entitled to: (1) request to be informed about the information collected about yourself on this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge. To request this information, contact Human Resources at 936.294-1872.

INSTRUCTIONS This form is used by Human Resources to review requested accommodations submitted by employees in compliance with *Finance & Operations Policy HR-05 Workplace Accommodations.*
Please do not use abbreviations on any of the fields.

Employee Name (print)	Sam ID	Date
Supervisor Name (print)	Job Title	
Employee's Department ***(Please do not abbreviate department name – print only)***	Employee's Work Phone	
Employee's Work schedule (*check all that apply*) Monday Tuesday Wednesday Thursday Friday Saturday Sunday Hours_____		

1. **What specific accommodations are you requesting? Please provide, if possible, a description (i.e., if you are requesting a piece of equipment or device, please provide description, manufacturer, cost, where to order, etc.).**

2. **If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore?** Yes No

3. **Is your accommodation request time sensitive? If yes, please explain in the space provided below?** Yes No

*Submission of this form is not required for disability accommodation requests, however the information requested, including medical certification of the diagnosis, prognosis, limitations on major life activity(ies), and recommended accommodation must accompany a request.

4. What, if any, job function are you having difficulty performing?

5. What, if any, employment benefit are you having difficulty accessing?

6. **What limitation is interfering with your ability to perform your job or access an employment benefit?**

7. **Have you ever had any accommodations or job modifications in the past for the same limitation? If yes, what were they and how effective were they?** Yes No

8. **How will accommodation assist you in performing the essential job functions of your job?**

9. **Please provide any additional information that might be useful in processing your accommodation request.**

I give Sam Houston State University permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate University personnel and/or my health care professional. I understand that all information obtained during this process will be maintained as confidential to the extent allowed by federal and state law. I understand that I will be required to provide appropriate medical documentation of my disability, including the impact of my limitations on my ability to perform the essential functions of my job. I further understand that once it is determined that accommodation is necessary, the University has the right to determine which effective accommodation will be provided.

_____

Employee name (print)

_____ _____

Employee name (signature) Date

SUBMIT FORM or for ASSISTANCE:
Human Resources Department
1831 University Ave, Huntsville Texas 77341
Fax 936.294.3611

Office Use Only

Date received	Received by