REASONABLE ACCOMMODATION
REQUEST FORM

(THIS FORM TO BE COMPLETED BY THE APPLICANT/EMPLOYEE)

All Information provided will be kept confidential, to the extent provided by law.*

Please complete this form and submit a copy to University Benefits. If you are requesting a reasonable accommodation related to a disability or other medical-related reason, please also submit a copy to your certified health care provider, along with copies of the *Health Care Provider Release Form*, to be completed by you and the *Health Care Provider Statement Form*, to be completed by your health care provider.

SECTION 1- APPLICANT/EMPLOYEE INFORMATION			
Name:			Job Applicant Current Employee Other:
Address:			Phone #: Email:
EMPLOYEE INFORMATION: **Complete this section if you are a current employee**			
Department/Unit:		Job Title:	
Work Phone #:	Manager:	Campus/Location:	

APPLICANT INFORMATION: **Complete this section *only* if you are a job applicant**

able to lift over 25 pounds for 3 months."
Describe the nature of the accommodation requested. (Present supporting documentation, as may be appropriate.)
Is the condition for which you are requesting an accommodation? -

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*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting