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OAKLAND CITY UNIVERSITY

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Employee Reasonable Accommodation Request Form

Name: _____ Dept.: _____

Phone: _____ E-mail: _____

Job Title: _____ Work Phone: _____

Immediate Supervisor: _____

What is/are the medical condition(s) which limit your ability to do your job? (Note: The information sought on this form pertains only to the condition for which you are requesting accommodation under the ADA.)

Does your medical condition affect a major life activity, i.e. caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning? Please explain which life activity(ies) is (are) affected.

How long have you had this medical condition? How long have you been treated for this medical condition?

Please provide a detailed description of the accommodation you are requesting.

What is the reason you need an accommodation? What things are you unable to do without an accommodation?

If you are requesting a type of equipment or a device, please describe the equipment. Do you know where the equipment can be obtained and about how much it costs? If so, please provide this information.

Is there any other information that would help us evaluate your request?

Please be sure to attach the ADA medical certification form. **Your request for reasonable accommodation cannot be processed without information from your health care provider. If this request form is not complete and/or the information from your health care provider is not received within 30 working days, the request for accommodation will not be processed due to non-response.**

"I give Oakland City University and its authorized representatives permission to explore coverage and reasonable accommodations under the ADA/Section 504. I understand this may include speaking to appropriate University personnel and/or my healthcare provider or professional and that all such information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job."

_____ Date _____

Signature of Person Requesting Accommodation: