(ADA-100)
FACULTY/STUDENT/RESIDENT REQUEST FOR ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT (ADA)

Individual Requesting Accommodation: _____

Position/Title: _____

Department/School: _____

Work Address: _____

Work Telephone Number: _____ Home Number: _____

Immediate Supervisor: _____ Phone Number: _____

ACCOMMODATION BEING REQUESTED: (use back to continue, if necessary)

_____

_____

_____

_____

_____

_____

REASON FOR ACCOMMODATION (identify condition and functional limitation(s) for which you seek an accommodation):

Condition: _____

_____

_____

_____

Functional limitation(s): _____

_____

_____

_____

INSTRUCTIONS FOR FACULTY/STUDENT/RESIDENT

PLEASE ATTACH OR PROMPTLY PROVIDE DOCUMENTATION FROM AN APPROPRIATE HEALTH CARE PROVIDER DESCRIBING YOUR FUNCTIONAL LIMITATIONS AND SPECIFYING THE MEDICAL CONDITION CAUSING THE FUNCTIONAL LIMITATIONS.

Faculty/Student/Resident Signature: _____ **Date:** _____

cc: ADA Coordinator