East Stroudsburg University
Human Resources Office

ADA Request for Accommodation Form

Date _____

Employee Name _____ Employee ID _____

Title _____ Department _____

Work Location _____ Supervisor _____

Work Schedule (days and hours) _____

Please use the back of sheet if you need more room to answer any questions listed below.

1. Please describe the physical or mental impairment(s) that limit(s) your ability to do your job.

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

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

2. Describe the accommodations you are requesting. Be as specific as possible (i.e., if you are requesting a piece of equipment or devise, please provide description, manufacturer, cost, where to order, etc.).

    a. If you are unsure of what accommodation is needed, do you have any suggestions?

    b. Have you had in accommodations in the past for this same limitation? ___Yes ____ No

    If yes, what were they and how effective were they?

3. Describe how the requested accommodations will enable you to perform your job.

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4. Please describe the expected duration of the requested accommodation:

   - ☐ Permanent
   - ☐ Until _____

5. Please provide any additional information that might help HR evaluate your request.

Signature _____ Date _____

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Release of Information for Employees

I, _____, understand that I am giving permission to _____ of the East Stroudsburg University Human Resources Office to contact the following individual(s) for purposes of requesting documentation/information regarding my disability including the diagnosis and limitations associated with that diagnosis. I understand that that this permission will remain in effect from the day I sign this document until I revoke permission in writing or am no longer affiliated with the Office of the Chancellor of the Pennsylvania State System of Higher Education.

Name _____
Address_____
_____
Phone _____ E-mail _____

Name _____
Address_____
_____
Phone _____ E-mail _____

Name _____
Address_____
_____
Phone _____ E-mail _____

I understand that communication with the above named individual(s) will not include personal disclosures that do not pertain to my disability(ies). I understand that all medical information related to my request for accommodation is confidential and will be maintained in a secured location within the Human Resources Office separate and apart from my personnel file. I further understand that I will be required to provide appropriate documentation of my disability, including the impact of functional limitations on my ability to perform the essential functions of my job.

_____ _____
Signature Date

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Request for Accommodation Checklist

TASK	DATE	HR Initials
Employee self-identifies to HR.		
Job analysis completed and submitted by supervisor.		
Essential functions analysis completed and submitted by supervisor.		
Job description and job analysis attached to medical certification and given to employee for completion.		
Medical certification received by HR.		
Determination of eligible disability made by HR. Determination: ☐ Yes ☐ No		
Accommodations identified, if applicable.		
Accommodations agreed upon by employee and Supervisor, if applicable.		
Accommodation agreement signed by employee, if applicable.		

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ADA Medical Certification

Note: *The information sought on this form pertains only to the condition for which the employee is requesting accommodation under the ADA.*

To be completed by Employee

Employee Name _____ Employee ID _____

Title _____ Department _____

Employee Signature _____ Date _____

To be completed by Health Care Provider

Instructions: Attached are copies of the employee's job description and a job analysis which indicates the essential functions of the position and includes the physical/mental demands and the environmental conditions associated with the job. **Please review both the attached job description and job analysis and prior to completing this form.**

Physician Name _____

Specialization/Type of Practice _____

Address _____

Phone Number _____

Questions to help determine whether an employee has a qualifying disability.

1. Does the employee have a mental or physical impairment? ☐ Yes ☐ No
2. What is the impairment? _____
3. Is the impairment long-term or permanent? ☐ Yes ☐ No
4. If **not** permanent, how long will the impairment likely last? _____
5. Is this condition considered a chronic condition which:
   a. Requires periodic visits for treatment by a health care provider? ☐ Yes ☐ No
   b. Continues over an extended period of time? ☐ Yes ☐ No
   c. May cause episodic rather than a continuing period of incapacity? ☐ Yes ☐ No
6. Does the impairment mean that the employee is substantially limited in one or more major life activities? ☐ Yes ☐ No
7. If yes, what major life activity(s) is/are affected?

☐ caring for self ☐ walking ☐ hearing

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☐ lifting	☐ interacting w/others	☐ standing
☐ seeing	☐ sleeping	☐ performing manual tasks
☐ reaching	☐ speaking	☐ concentrating
☐ breathing	☐ thinking	☐ learning
☐ working	☐ toileting	☐ sitting
☐ reproduction	☐ other: _____	

Questions to help determine whether an accommodation is needed.

1. What limitation(s) in major life activities is/are interfering with this employee's job performance?

2. What job function(s) listed in the attached job description and job analysis is the employee having trouble performing because of the limitation(s)?

3. How does the employee's limitation(s) in major life activities interfere with his/her ability to perform the job functions listed in the attached job analysis?

Questions to help determine effective accommodation options.

1. Do you have any suggestions regarding possible accommodations to improve job performance? If so, what are those suggestions?

2. How would your suggestions improve the employee's performance?

Additional comments

Health Care Provider Signature _____ Date _____

All information provided is confidential and will be retained in the employee's medical file.

Return form to:

Human Resources Office, 200 Prospect Street, East Stroudsburg, PA 18301
Fax: 570-422-3450