



Employee Accommodation Request Form

This form should be completed by the employee requesting a workplace accommodation due to a qualifying disability. **The signed document should be faxed to the Office of Human Resources at 614-292-0271.** Supporting medical documentation may be required. You should discuss potential accommodations with your health care provider. This form and supporting documentation from your health care provider will be reviewed to determine what reasonable accommodations, if any, are appropriate. The Job Accommodation Network online at askjan.org may be a helpful resource.

COMPLETED BY EMPLOYEE

Employee Name Employee ID

Job Title Department Regular Work Schedule

Job Duties

1. What, if any, job functions are you having difficulty performing due to your medical condition/disability?

2. What specific accommodation(s) are you requesting and how will it assist you? *(A workplace accommodation is a modification to policy or practice, the provision of tools and software, or a modification to the environment that lessens the impact of a disability to allow an employee to perform the essential functions of the job.)*

3. Have you had any accommodations in the past for this same limitation? Yes No
If so, what were they and how effective were they?

4. Please provide any additional information that might be useful in evaluating your accommodation request.

Employee Signature Date