THE OHIO STATE UNIVERSITY

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 614-688-8120**. 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?

   _____

   _____

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   _____

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

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Employee Signature _____ **Date** _____