EMPLOYEE REQUEST FOR DISABILITY ACCOMMODATION FORM

Lurleen B. Wallace Community College

Directions: Employees requesting disability status or requesting reasonable accommodations with regard to a qualifying disability in accordance with the Americans with Disabilities Act must complete this form and submit the form to the Human Resources Coordinator. Upon submission of this form and any required documentation, the Dean will review your all information and inform you of your status as an employee with a disability and/or your request for reasonable accommodation.

Name_____ Employee ID_____
First Middle Initial Last

Phone Number (____)_____ Phone Number (____)_____ E-mail_____
(Circle One) Home/Cell/Work Home/Cell/Work

Current Title _____ Division_____

Immediate Supervisor _____

Explain your disability_____

_____

_____

What, if any, job function(s) are you having difficulty performing? _____

_____

_____

What limitation(s) is interfering with your ability to perform your job? _____

_____

_____

Are you currently under the care of a physician for this disability: Yes ☐ No ☐
If you answered "yes" above, describe the current treatment. _____

_____

Do you take prescription medication for this disability? Please name the prescription, the dosage and the physician who prescribed it.

_____

_____

What specific accommodations are you requesting and how will that accommodation assist you? _____

_____

_____

Have you ever received workplace or disability accommodations? Yes ☐ No ☐
If *yes*, what were they and how effective were they? _____

_____

Do you receive assistance from Vocational Rehabilitation, Veteran's Affairs, or any other agency related to this disability? Yes ☐ No☐
If you answered "yes" above, please name your counselor or contact person and his/her employing entity.

_____

_____ _____ _____
Signature Printed Name Date