Employee ADA Accommodation Request Form

Employee Name: ________________________ Date of Request: __________________
Panther ID: ______________________________
Employee Mailing Address: ____________________________________
City State/Province/Region Country_____________________________
Email: _________________________ Mobile Phone: _____________________
Office Phone: __________________ Campus: _________________________
Location: ______________________ Department: _______________________
Title: ___________________________
Classification: ☐ Faculty ☐ Administrative ☐ Staff ☐Temporary ☐ Other:
Supervisor: ________________________ Supervisor's Phone: _________________

Are you currently registered with the Office of Civil Rights, Compliance and Accessibility (Formerly IDEA)? ☐ Yes ☐ No

If *yes*, with what type of disability?

☐ Hearing ☐ Speech ☐ Learning ☐ Physical ☐ Visual ☐ Medical ☐ Other:

QUESTIONS TO CLARIFY ACCOMMODATION REQUESTED
Please describe the accommodation you are requesting at this time:

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Describe your physical work area/environment, including your office space, the type of interactions you have on a daily basis, and whether you are currently coming to campus on a full-time schedule.

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If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore. ☐ Yes ☐ No
If *yes*, please explain

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Is your accommodation request time sensitive? ☐ Yes ☐ No
If *yes,* please explain

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For what time period will the reasonable accommodation be needed? __________________

Do you anticipate that your need for the accommodation will be recurring? ☐ Yes ☐ No
If *yes,* please explain

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QUESTIONS TO DOCUMENT THE REASON FOR ACCOMMODATION REQUEST
What, if any, job function are you having difficulty performing?

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

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What limitation is interfering with your ability to perform your job or access an employment benefit?

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Have you had any accommodations in the past or this same limitation? □ Yes □ No
If *yes,* what were they and how were they effective?

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If you are requesting a specific accommodation, how will that accommodation assist you?

____
____

Describe the type of reasonable accommodation including any special equipment, assistive technology, mobility aids or auxiliary aids that you use or could use to perform the essential functions of your job.

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OTHER INFORMATION
What is the treating physician's name and contact information? (phone, email, fax number):

Physician Name: ___________________________________
Physician Phone Number: ____________________________
Physician Email: ___________________________________
Physician Fax Number: ______________________________

Are you registering a new disability? □ Yes □ No
If *yes*, with what type of disability?

□ Hearing □ Speech □ Learning □ Physical □ Visual □ Medical □ Other:

In case of an emergency, who would you like CRCA to contact? a. Name:
b. Relationship: ______________________
c. Primary Phone: ____________________
d. Secondary Phone: __________________

I hereby certify that all statements made above are true and accurate to the best of my knowledge and belief. I hereby authorize the release of the above information to Florida International University for the purpose of determining if I am a qualified individual with a disability and the appropriateness of the requested reasonable accommodation(s) under the American with Disabilities Act (ADA). I understand that it will be my responsibility to complete a Release of Information Form and to furnish a Physician's Verification of Disability, if required, to Florida International University for my request to be evaluated. I further authorize Florida International University to seek clarification of this document and the Physician Verification of Disability, if necessary, by contacting my physician(s) or healthcare provider(s). I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements and the Health Insurance Portability Accountability Act of 1996 (HIPPA).

______________________________ _______________

Signature Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.