Middle Georgia State University
OFFICE OF HUMAN RESOURCES

ADA: Employee Accommodation Request Form

Reasonable accommodations may be needed to provide equal access and opportunities to qualified individuals with disabilities. If you are an employee with special needs that are the result of a disability and you believe that reasonable accommodations will assist you in the performance of your job, please complete this form and return it to the Office of Human Resources.

Name:_____ Employee ID #:_____

Job title _____ Work phone _____

Department: _____ Work locations (bldg.)_____

Supervisor/Department Head: _____

Work schedule (Days & hours) _____

_____

Nature of the qualifying disability: _____

_____

Requested/Suggested Accommodation *(Please describe the accommodations you believe are needed to enable you to perform the essential functions of your job)*:

_____

_____

Time frame needed: _____

Physician Contact Information *(Please provide name, address, telephone, and fax numbers. The physician may receive a letter/fax from us requesting information on your impairment/disability and recommendations for accommodations).*

_____

_____

_____

I give Middle Georgia State University permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate university personnel and/or my health care professional. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that this request must be supported by appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.

_____

Signature Date

Middle Georgia State University
OFFICE OF HUMAN RESOURCES

Health Information Release Waiver for ADA Accommodations

_____
Employee Name (please print)

_____
Job Title **Department**

_____
Campus **Work Phone Number**

I, (please print name) _____, am requesting reasonable accommodations for my medical condition(s) through my employer, Middle Georgia State University. I give representatives of the Office of Human Resources permission to speak with and/or request written information regarding medical assessment(s) on my behalf. I authorize my health care practitioner(s) to release relevant information regarding my medical condition. I understand that this information will be in confidence and used only for purposes of approval of reasonable accommodations under the Americans with Disabilities Act (ADA).

_____ _____
Employee Signature **Date**

Please provide contact information for your health care practitioner(s) so we may forward the Medical Request for ADA Accommodations:

1. Health Care Practitioner's Name _____

Name of Practice _____

Mailing Address _____

Phone Number ( ) _____ Fax Number ( ) _____

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2. Health Care Practitioner's Name _____

Name of Practice _____

Mailing Address _____

Phone Number ( ) _____ Fax Number ( ) _____