COMMONWEALTH UNIVERSITY

Reasonable Accommodation Request Form

This form must be completed by an employee requesting reasonable accommodation(s) under the American with Disabilities Act of 1990 ("ADA"), Pennsylvania Human Relations Act, and Commonwealth University policies. Completed forms are to be returned to the ADA Coordinator.

1. NAME	2. DATE OF REQUEST
3. JOB/POSITION TITLE	4. DAYTIME TELEPHONE NO.
5. DEPARTMENT NAME/ADDRESS	6. EMAIL ADDRESS
7. SUPERVISOR'S NAME	8. SUPERVISOR'S TELEPHONE NO.

Please answer the following questions to assist the University in understanding the basis and nature of your request for an accommodation. The information you provide will be treated confidentially and will be handled on a need-to-know basis.

1. Identify the physical and/or mental impairment(s) for which you are requesting accommodation, when this impairment began, and the expected duration of the impairment.

2. Explain how the impairment(s) listed above substantially limits your major life activities, including but not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

3. Explain how the impairment(s) listed above affect(s) your ability to perform the essential functions of your position or access employment benefits. Be as specific as possible regarding the job duties you are having difficulty performing or believe you will have difficulty performing.

4. Describe any type of reasonable accommodation which you believe will enable you to perform the essential function(s) of the position or access employment benefits.

5. Describe how this accommodation will assist you in performing the essential functions of the position or improve access to employment benefits.

6. If you have had any reasonable accommodation in the past for this same limitation, describe those accommodations and how effective they were.

7. Do you have documentation to support your disability? YES _____ NO _____ If YES, please attach. [Documentation includes statements or other documentation from a physician or other professional identifying the disability and addressing what limitations of major life activities are caused by this disability, and what, if any, reasonable accommodations are necessary based upon your job duties. [See Medical Certification Form for additional information]. If you need a copy of a job description to provide to your medical professional, please contact HR.

Acknowledgement

I understand that it is my responsibility to complete the attached Release of Medical Information Statement and to provide a Medical Certification Statement to the ADA Coordinator for my request to be evaluated. I further understand that the ADA Coordinator will evaluate and respond to me based upon the information that I provide.

SIGNATURE	DATE
RECEIVED BY ADA COORDINATOR	DATE

Information or assistance regarding accommodation requests can be obtained by contacting CUADA@commonwealthu.edu