ELIZABETH CITY STATE UNIVERSITY

Request for Reasonable Accommodation Form

To request a reasonable accommodation under the Americans with Disabilities Act (ADA) from the University, an applicant or employee must complete this form and submit it to the Equal Opportunity/ADA Officer or Human Resources. The information you provide will be kept confidential consistent with State and Federal law—separate from the applicant's employment file and the employee's personnel file.

The purpose of this form is to assist ECSU in determining whether, or to what extent, a reasonable accommodation under the ADA is required for an applicant/employee to perform one or more essential functions of the job safely and effectively.

Personal Information – To be completed by the Applicant/Employer

Name: _____ Gender: ☐ Male ☐ Female

Department/Unit: _____ Position/Title: _____

Employment Status: ☐ EHRA ☐ SHRA ☐ Permanent ☐ Temporary ☐ Applicant

Campus Phone #: _____ Email Address: _____

Phone # (Home/Cell): _____

Mailing Address, (Please include Campus Box # if office address): _____

_____

Supervisor: _____ Phone #: _____

Current Work Schedule/Shift: _____

Former/Existing Accommodations: _____

_____

University Offices Contacted: _____

_____

Date of Hire: _____

Disability Information:

1. Please indicate the nature of your disability:

☐ Visual Impairment
☐ Hearing Impairment
☐ Mobility Impairment
☐ Respiratory Impairment
☐ Speech Impairment
☐ Nervous System/Neurology Disorder
☐ Mental/Psychological Impairment
☐ Learning Disability
☐ Other (Please Describe)

2. Is your disability:

☐ Temporary (If so, how long?) _____
☐ Permanent _____

3. Please briefly describe any limitations or restrictions caused by your disability. Identify and describe the essential function(s) of the position (listed on page 1) which you are unable to perform without reasonable accommodation(s) by the University:

_____
_____
_____
_____

4. Please list any accommodation(s) or service(s) related to your disability that would enable you to perform the essential functions of the position properly and safely, including special equipment, changes in the physical layout of the job, special methods, skills or procedures, or other accommodation(s):

_____
_____
_____
_____

5. Identify and describe any equipment, aids or services that you are willing to provide and utilize:

_____
_____
_____
_____

Certification:

I certify that I have read and reviewed the job description for the position and/or have been informed of the essential functions of the job. I further certify that the foregoing statements are complete, accurate and true to the best of my knowledge and I understand that misstatement or omission of fact may be cause for dismissal. I also understand the University may require me to undergo testing or evaluation by medical personnel for the purpose of establishing the existence and extent of my disability, illness, condition, or disease and my ability to perform job-related functions with or without reasonable accommodation under the ADA.

I understand that I must also follow the procedures outlined in the Reasonable Accommodation Policy (Policy 200.1.19) which include completing the Release of Information and Acknowledgment Form and having an authorized physician or other health care provider submit a signed Documentation of Disability Form on my behalf. This form should include a description of my disability, any related limitations, and recommendations for accommodation(s) and/or service(s).

I hereby agree that Elizabeth City State University is permitted to share relevant information from my physician or other health care provider(s) with the supervisor(s) in the immediate work unit and other university offices that may be involved in assisting in the development of reasonable accommodation(s) to assist me in completing my assigned work related responsibilities.

I further understand that the University is not obligated to provide any specific accommodation(s) I request, but will evaluate my request in light of all information available in making a determination of what is a reasonable accommodation under the ADA.

_____
Name

_____ _____
Signature Date

IMPORTANT: Please Enclose Job Description/Classification Specifications for Your Physician/Health Care Provider.