

## REASONABLE ACCOMMODATION REQUEST FORM

I request that Bowling Green State University provide me with a reasonable accommodation to perform one or more essential functions of my job safely and effectively. *I understand that this form will be maintained separately from my official personnel file.*

### EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_

Telephone: (W) \_\_\_\_\_ (H) \_\_\_\_\_

Campus Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Job Title: \_\_\_\_\_

College/Administrative Area: \_\_\_\_\_

Department/Unit: \_\_\_\_\_

Department Head/Supervisor: \_\_\_\_\_ Telephone: \_\_\_\_\_

### REQUEST

I believe that the following accommodation will allow me to perform the essential function(s) of my job:

\_\_\_\_\_  
\_\_\_\_\_

### DESCRIPTION OF HEALTH CONDITION

I believe I have a "disability" as defined under the University's Equal Employment Opportunity Policy because: \_\_\_\_\_

(describe health "condition")

\_\_\_\_\_

*(Attach additional numbered pages, if necessary)*

This condition has prevented me from performing the following essential function(s) of my job:

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*(Attach additional numbered pages, if necessary)*

### **AUTHORIZATION AND ACKNOWLEDGEMENT**

I authorize Bowling Green State University, Office of Disability Services, to investigate my eligibility and qualifications for an accommodation under the Americans with Disability Act. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements.

I understand that I am being requested to complete and sign the *Patient/Employee Authorization for the Release of Protected Health Information* form giving Bowling Green State University authorization to consult with my health care provider(s) and/or to receive my protected health information. This information will be used to determine if I am a qualified employee with a disability. If I fail to sign that form, I understand that the University will act on my request for an accommodation without the benefit of such consultation and/or information.

Date: \_\_\_\_\_

Employee's signature: \_\_\_\_\_