EMPLOYEE ACCOMMODATION REQUEST

1. NAME: ____

2. TELEPHONE: ____

3. POSITION: ____

4. DEPARTMENT: ____

5. SUPERVISOR/DEPARTMENT HEAD: ______________________________

6. DESCRIBE THE QUALIFYING DISABILITY: ______________________________

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7. REQUESTED/SUGGESTED ACCOMMODATION: (Please describe the accommodations you believe are needed to enable you to perform the essential functions of this job and state the time period for which you are requesting accommodation.

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8. HEALTHCARE PROVIDER CONTACT INFORMATION: (Name, address, telephone and fax numbers. The healthcare provider may be contacted by HR requesting information on your impairment/disability and recommendations for accommodations.)

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I authorize and request the Office of Human Resources to consider this request for accommodation and all documentation provided in connection with this request as it deems necessary for the evaluation of my eligibility for accommodation. I further authorize it to consult with other educational and healthcare professionals and my supervisor/department head, disclosing only such information as it deems relevant for consultation.

I authorize the release of medical information from my healthcare providers regarding my disability to The University of the South's Office of Human Resources.

Signature: ____

Date: __________________________________