Accommodation Request Form

East Carolina University is committed to compliance with the Americans with Disabilities Act (1990) and the Americans with Disabilities Amendments Act (2008). The purpose of this form is to assist East Carolina University in determining whether, or to what extent, a reasonable accommodation will allow an employee to perform the essential functions of his or her job safely and effectively.

Name:_____________________________  Department:_________________________________________

Position:___________________________  EPA Faculty ___ EPA Staff ___ SPA ___ Perm ___ Temp ___

Banner ID: _________________________ Work phone # ______________  Home/Cell _______________

Name of Supervisor _______________________________ Supervisor phone # ______________________

The statutory definition of disability is a person with a physical or mental impairment that substantially limits one or more of the major life activities of such individual.

According to the Americans with Disabilities Amendments Act, major life activities may include but are not limited to the following, please check all that are impacted by your physical or mental impairment:

- caring for oneself
- performing manual tasks
- seeing
- hearing
- eating
- sleeping
- walking
- standing
- lifting

- bending
- speaking
- breathing
- learning
- reading
- concentrating
- thinking
- communicating
- working

Also included are functions of

- the immune system
- digestion
- the bowels
- the bladder
- reproduction
- the endocrine system

- normal cell growth
- circulation
- neurological processes
- the brain
- respiration
Please describe the physical or mental impairment(s) for which you are requesting accommodation:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
What are the limitations or restrictions caused by your condition(s)?
____________________________________________________________________________________
____________________________________________________________________________________
Is the condition permanent? _______________ Temporary (If so how long?) ______________________
If the condition is episodic and does not limit you on a daily basis, how often do you experience
symptoms that will necessitate accommodation? ____________________________________________
Have any accommodations or adjustments been put in place by your supervisor?___________________
If yes, please describe:
____________________________________________________________________________________
____________________________________________________________________________________
Have the accommodations been successful? ________________________________________________
What accommodations or adjustments to the workplace will assist you in performing the essential
functions of your job?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
By my signature below, I agree that, in order to assist in the development of reasonable
accommodations, the ADA Coordinator may share relevant information from my health care
professionals with my immediate supervisor(s).

Other offices on campus that may be consulted on a case by case basis include:

- Human Resources for analyses of essential job functions and options related to FMLA, short
  and long term disability
- The Office of Prospective Health when a fit for duty evaluation is indicated
- Environmental Health & Safety to assist with ergonomic and safety issues
- Facilities when physical adjustments to the workplace are needed

I understand that I must also submit the “ADA Disability Verification Form” completed by my
appropriate health care provider, to the Office of the ADA Coordinator.

______________________________  ________________  ________________________________
Signature                              Date