



### 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, through its ADA Coordinator, in determining whether, or to what extent, a reasonable accommodation will allow an employee to perform their job safely and effectively. Return completed forms to the ADA Coordinator. Employee medical information and requests for accommodation are confidential. This information is not kept in an employee’s primary personnel file.

Name: \_\_\_\_\_ Department: \_\_\_\_\_

Position: \_\_\_\_\_ Faculty \_\_\_\_\_ NF-EHRA \_\_\_\_\_ SHRA \_\_\_\_\_ CSS \_\_\_\_\_

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

Other: \_\_\_\_\_  
\_\_\_\_\_

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 or implementation of reasonable accommodations, the ADA Coordinator may share relevant information from me or my health care professionals with my immediate supervisor(s). The ADA Coordinator will only share the minimum amount of information necessary to evaluate and/or implement my request. For example, the ADA Coordinator may need to share specific functional limitations that are the basis for reasonable accommodations, in order to evaluate my request for an accommodation.

Additionally, the ADA Coordinator may also consult with the following offices on campus as necessary and on a case by case basis:

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date