# ADA Reasonable Accommodation Request Form

Date: _____

Employee's Name: _____

Job title: _____ Department: _____

Supervisor's name: _____

Describe the nature, extent and duration of any impairment that limits your ability to perform the essential functions of the job:

_____

_____

Are you currently capable of working? If not, when will you be capable of returning to work?

_____

_____

Describe the accommodations you believe are needed to enable you to perform the essential functions of this job. With respect to each proposed accommodation, please specify the accommodation and describe how long those accommodations will be required:

_____

_____

When you are able to return to work, are there any essential functions of the position that you will not be able to perform even with reasonable accommodations? If so, please identify.

_____

_____

Provide the name, address, telephone and fax numbers of your health care provider. The provider may receive a request from us for information regarding your impairment/disability and recommendations for accommodations.

_____

_____

Attach any supporting documentation that may be helpful in evaluating this request for accommodation.

I authorize the release of information regarding my disability to ALPA management as deemed necessary by ALPA Human Resources to facilitate this request for accommodation.

**Employee signature:** _____

**Date:** _____

Disposition of Request:

_____ Approved

_____ Modified

_____ Denied

Description of approved or modified accommodation: _____

_____

_____

_____

Duration/Re-evaluation: _____

**HR Signature:**_____

**Date**:_____