University of South Alabama (USA)
USA HealthCare Management, LLC (HCM)
USA Health Care Authority (HCA)

Employee Accommodation Request form

Request for Reasonable Accommodation

Employee Information		
Staff ☐ Faculty ☐ Administrator ☐		
Email:	Work phone:	Cell Phone:
Name:	Jag#:	Date:
Current Address:		
City:	State:	Zip code:
Department/School:	Supervisor/Phone #:	

QUESTIONS TO CLARIFY ACCOMMODATION REUQESTED

1. **Please describe the physical or mental or cognitive impairment(s) which limits your ability to perform the essential functions of your job.**

2. **Describe how your condition limits your ability to perform the essential functions of your job.**

3. **What specific accommodation are you requesting:** (be as specific as possible. i.e. if you are requesting a piece of equipment or a device, please provide description, manufacturer, cost, where to order, if known)

4. **If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? Yes ☐ No ☐**
   If yes, please explain:

5. **Is your accommodation request time sensitive? Yes ☐ No ☐**
   If yes, please explain:

6. Is your impairment temporary or permanent? If temporary, how long do you expect to be impaired?
7. Please describe any other information that might help the University of South Alabama/USA HealthCare Management, LLC/USA Health Care Authority. evaluate your request:
I have voluntarily completed this Employee Accommodation Request form and all information provided is true and accurate. I hereby certify that the information hereunder is correct to the best of my knowledge and understand that falsification of this information is grounds for disciplinary action, up to and including termination. I give USA/HCM/HCA permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act. This may include speaking to appropriate USA/HCM/HCA personnel and/or my health care professional, and acknowledge that such communication is job-related and consistent with business necessity. I understand that all information obtained during this process will be maintained and used in accordance with ADA confidentiality requirements. I further understand that I may be required to provide appropriate documentation of my disability, including the impact of the functional limitations on my ability to perform the essential functions of my job.
Employee Signature: **Date:**

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AREA BELOW FOR OFFICE USE ONLY		
Request Granted: Yes ☐ No ☐	From (date):	To (Date):
Request Denied: (Please state reason for denial)		
Notes and/or Description of Accommodations: (If cost exceeds $500, approval of _____ is required.		
UNIVERSITY SIGNATURES		
Initial Contact Person:		Date: