|  |
| --- |
| **Employee Request for** **https://specials-images.forbesimg.com/imageserve/557f354ee4b017853ecec037/300x300.jpg?fit=scale&background=000000****Reasonable Accommodation Under the ADA**Carthage College ● Human Resources Office2001 Alford Park Drive, Kenosha, WI 53140Office: (262) 551-5774  |
| **INSTRUCTIONS:** This form is to be completed by the employee requesting an accommodation under the Americans with Disabilities Act. Please complete the Request for a Reasonable Accommodation form and submit the completed form to the Human Resources Department. Information received pertaining to an accommodation request is kept confidential to the extent possible and is maintained separate from personnel records. Medical Documentation will be required to support your request for a reasonableaccommodation. Please contact the Human Resources Department to obtain a form to use for providing the requested information. |
| **EMPLOYEE INFORMATION** |
| **Name:** | **Phone:** |
| **Address:** | **City/ST/Zip:** |
| **Job Title:** | **Department:** |
| **REQUEST** |
| Describe the essential functions, as listed on the attached job description, of your job that you are unable to perform and thereasons why. Please be specific. Attach additional sheets as necessary. Medical information pertaining to your disability will berequired on a separate form. It will be your responsibility to insure that your doctor provides sufficient, unambiguous information to the College so as to enable the College to efficiently and thoroughly review and respond to your request. |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Page 1 of 2

Describe the accommodation(s) requested. How will the accommodation assist you in performing the essential functions of your job? If an unpaid leave of absence is requested, what is the purpose for the additional leave? How long of a leave of absence are you requesting? Do you intend to return to work full time? If so, what is your expected date of return? Attach additional sheets as necessary. Please be specific.

**HEALTH CARE PROVIDER INFORMATION**

|  |  |
| --- | --- |
| **Name:** | **Phone:** |
| **Address:** | **City/ST/Zip:** |



**The undersigned has read and understands this form. The responses that I have provided thereto are complete and truthful.**

**Employee Signature: Date:**

**Office Use Only:**

For Date Received By:

Revised 09.14.18

Page 2 of 2