

Voluntary Request for Reasonable Accommodation Form

If you have a disability that is covered (protected) under the American with Disabilities Act (ADA) or Section 504 of the Rehabilitation Act of 1973, or other applicable state laws, and you are a qualified individual, you are entitled to request a reasonable accommodation. A reasonable accommodation will be provided to the extent that it does not pose an undue hardship and may be requested for the following purposes:

- To complete the employment application process
- To perform essential job functions
- To have equivalent benefits and privileges as non-disabled employees.
- To obtain evacuation assistance in a time emergency.

Advance notice is usually required to fulfill Reasonable Accommodation requests. However, a response to immediate need for accommodation will be made to the fullest extent feasible.

Date: _____

Name: _____

Department: _____

Supervisor: _____

Job Title: _____

Home Address: _____

Home/Cell
Phone: _____

Home Email Address: _____

Work Email
Address: _____

Do you have a physical disability or significant impairment of mobility, vision, hearing or other function for which a reasonable accommodation might be made in order for you to perform the essential functions of your job?

No ___ Yes ___
(If yes, please identify disability and needed accommodation in the appropriate section below)

Documentation of Protected Status

When requesting Reasonable Accommodation, be prepared to submit appropriate and current medical documentation or other documentation from a professional qualified to make an assessment of your condition. Additional documentation may be needed if there is an ongoing need for the accommodation. All such documentation will be treated confidentially.

I am requesting accommodation for the following reason(s):

(Please check relevant boxes)

- To complete the employment application process
- To perform essential job functions
- To have equivalent benefits and privileges of non-disabled employees
- To obtain evacuation assistance in time of emergency

How does your limitation restrict your ability to accomplish or obtain the item(s) checked above? If related to the performance of job responsibilities, state the job functions for which you need an accommodation, and describe the difficulty you have performing that task.

What type of accommodations do you believe would be effective?

For those accommodations that must be purchased or attained, please identify possible resources for the department to consider in responding to the accommodation request:

How long will you need this accommodation? Short-term _____ Ongoing _____

I CERTIFY THAT THE ABOVE STATEMENT AND ALL INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

Name: _____
(Please print)

Please return this completed form in a sealed envelope to: Director of Operations, Five Colleges, Incorporated, 97 Spring Street, Amherst, MA 01002. Mark the envelope CONFIDENTIAL.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services